

Avonpark Village (Care Homes) Limited

Fountain Place Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Good 

Summary of findings

Overall summary

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At the last comprehensive inspection we identified that the service was not meeting the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and served warning notice on Regulation 12 Care and Treatment and imposed conditions on the registration of this service. The provider developed a comprehensive action plan detailing how they would take steps to address the conditions of registration, the warning notices and meet the other requirements they had breached.

This inspection was unannounced and took place on the 22 February 2017. Fountain place is registered to provide accommodation for up to 17 people who require nursing and/or personal care. At the time of our visit three people were accommodated.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicine systems were safe overall. Although staff signed medication administration records (MAR) when they administered medicine, MAR charts were not always signed when topical creams were applied. There were PRN (Medicines to take as required) protocols in place and when these were administered, staff documented when they had been given and the reasons why.

Staffing levels were adequate to meet people's needs despite the high levels of agency staff used. The same agency staff were used to ensure continuity of care was provided. Recruitment of new staff was in progress and the recruitment process was robust.

The people said they felt safe living at the home. Staff knew the procedures for protecting people from abuse and harm. Staff were knowledgeable and understood their responsibilities in reporting any potential abuse. Staff had attended safeguarding training and were aware of the procedures to be followed for reporting abuse.

People received care and treatment from staff that were supported to meet the responsibilities of their role. Members of staff said the training provided was good with pathways for progression within the organisation. One to one meetings took place regularly with their line manager. Annual appraisals were to take place.

People were able to make their own decisions and told us who helped them make complex decisions if they required support.

Care plans were person centred and were reviewed to ensure people's changing needs were met. They contained lifestyle profiles with people's preferred routines documented. Risk assessments formed part of the care plans and action plans gave staff guidance on how to minimise the risk. However, action plans had not always been followed in monitoring people's fluid intake.

Quality assurance systems were in place to monitor the quality of the service. The feedback from relatives had been sought on the quality of the service. Members of staff told us the team worked well together and they were supported to meet the requirements of their role. An agency worker told us they worked at the service regularly to provide continuity of care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe

Members of staff were able to tell us the safeguarding procedures including the types of abuse people may be vulnerable to.

Staffing levels were maintained with the use of agency staff. Permanent staff said the same agency staff were used at the service.

Risks were assessed and action plans developed to minimise risk. Action plans were not always followed regarding the monitoring of fluid intake.

Safe systems of medicine management were found although the application of topical creams were not always recorded.

Is the service effective?

Good 

The service was effective.

People were able to make day to day decisions and told us who helped them with complex decisions if they needed this support.

Staff attended essential training that the provider deemed as necessary for their role. One to one meetings with the line manager took place regularly so staff had the opportunity to discuss their performance, areas of concern and future development.

People had access to health care professionals for their ongoing healthcare needs.

Is the service caring?

Good 

The service was caring.

People received care and treatment from permanent staff that knew their needs and respected their human rights.

Members of staff were respectful and consulted people before

they offered support

Is the service responsive?

The service was not consistently responsive

People's needs were assessed and care plans were based on people's preferences. Care plans were person centred and reviewed regularly to ensure people's changing needs were met.

There was an activities programme in place and people were encouraged to pursue their hobbies and interests.

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Requires Improvement 

Is the service well-led?

The service was well led

The provider had developed effective systems to assess, monitor and improve the quality of care.

Staff felt they were supported by management to raise any concerns or question poor practice.

The views of relatives had been gathered on the quality of the service.

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Good 

Fountain Place Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 22 February 2017. At the time of the inspection three people were living at the service.

The inspection was conducted by two inspectors and one Expert by Experience. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.'

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use the service. This included the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one person who used the service about their views on the quality of the care and support being provided. We looked at documents that related to people's care, support and the management of the service. We reviewed a range of records which included three care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we spoke with the regional manager, the registered manager, one agency registered nurse and two care staff.

Is the service safe?

Our findings

At the comprehensive inspection in May 2016 we took enforcement action and served warning notice on Regulation 12 (Care and treatment must be provided in a safe way for service users). We found people were not always protected from the risk of harm. Whilst risks had been identified, people's care plans did not always contain guidance for staff on how to minimise the risk. Accidents and incidents were not always recorded appropriately and reported to the management team for investigation to follow up actions where necessary. The number of staff employed was not adequate to cover all shifts and agency staff were used to cover shortfalls.

We then undertook a focused inspection in August 2016 to check the provider had followed their action plan and to confirm they were meeting the necessary legal requirements. We found the provider had taken action to address the issues highlighted in the warning notices.

At this inspection we found that medicines were mostly managed safely. Medicine administration records (MAR's) contained up to date photographs of people and allergies were listed. There were PRN (Medicines as required) protocols in place and when these were administered, staff documented when they had been given and the reasons why. The service used a monitored dosing system, but when boxed medicines were in use, stock levels were checked daily. Fridge items were stored in medicine fridges and the temperatures of these were monitored daily.

Although no gaps were seen in the MAR charts, associated records of administration were not consistently signed in relation to the administration of topical creams and lotions. In Fountain Place, the nurses signed the MAR chart to indicate creams had been applied. The agency nurse on duty said they did not sign the MAR until the creams had been applied. There were also TMAR (topical MAR) charts in place in people's rooms for staff to sign when they had applied them. However, not all of these had been signed consistently. For example, one person had been prescribed a cream for daily use but the chart had not been signed on three days during the previous week. Despite this, the MAR chart had been signed by the nurse.

People told us the staff administered their medicines. They said staff explained the purpose of their medicines. One person said "Yes I get my medication when I should as far as I am aware. I am as informed as I want to be, - you can always ask the staff are approachable (some more than others)."

Care plans contained risk assessments for areas such as falls, moving and handling and maintaining a safe environment. Where risks were identified the care plans provided clear guidance to staff on how to reduce the risks. Where people had expressed a wish to remain as independent as possible, the care plans detailed this. For example, in one person's care plan it had been documented that they were keen to maintain their independence, but also wanted staff to supervise them during transfers in order that they felt safe. When people were unable to transfer independently, details of which hoist and which sling should be used was in place.

People had been assessed who were at risk of dehydration and malnutrition. However, the documentation in place was a combination of the provider's tool and a national tool and these gave conflicting scoring guidance for staff when assessing the risks. We discussed this with the manager during our inspection and they said they would ensure only one tool was used.

People's weights were monitored regularly. When people gained or lost weight, advice was sought from the GP. Where people had gained weight which may affect their mobility a weight loss programme was developed and the care plan detailed how staff were to encourage healthy eating. For example "Reduce portion sizes, offer fruit instead of puddings". They were having their weight monitored and had steadily lost weight over the previous five months.

Another person had been assessed as a medium risk of choking. They had been referred to the speech and language therapist (SALT). The care plan detailed the recommendations, such as a textured diet and to assist the person with their meals using a teaspoon. We observed a member of staff assisting this person with lunch and the recommendations were being followed.

Another person had been assessed at risk of malnutrition. They had also been referred to the GP and to the SALT team. Staff had monitored the person's weight and when they continued to lose weight a referral had been made to the dietician for additional advice. The person was having their food and fluid intake monitored. These had been completed in full, although on two days the person had a recorded intake of 735 millilitres and 860 millilitres which was below the daily target. There was a lack of recording regarding the person's reduced fluid intake.

Incidents and accidents were reported and investigated. When accidents happened, people were monitored closely for 24 hours afterwards to observe for any adverse effects.

There was enough staff on duty to meet people's needs. However, there were only three people using the service on Fountain Place. One member of staff said "At the moment, yes, we have enough staff. Normally, even we're full, we have enough". Although the service was reliant on agency staff, the agency nurse on duty worked on Fountain Place three days a week and was considered a member of the team by the manager. They said "I've worked here regularly for eight months now so I know the residents really well. I was asked to work three days a week in order to give residents and staff continuity. Even if I need a day off, the permanent nurse swaps shifts with me, so that continuity is maintained".

We saw safe recruitment and selection processes were in place. We looked at one staff file and found that appropriate checks had been undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

The people we spoke with said they felt safe living at the service. One person said "Yes I feel safe here, staff are very dedicated, good and helpful, they pay attention to our needs". Another person said "I like living here. Yes I feel safe here and it is a pleasant place".

Staff had completed safeguarding training. Through scenario based questions they demonstrated that they knew what abuse was and how to report any concerns. An agency worker said "I'm happy to raise any concerns, I've done so before and the [registered] manager took my concerns seriously". Other staff said "I would speak to the nurse on duty, or the manager. If I wasn't taken seriously I would speak to CQC".

Staff understood the provider's policy in relation to whistleblowing and all confirmed that they knew how to report any concerns they had. All staff confirmed that if they did not receive an adequate response from the manager, they would go to senior management or would contact CQC.

Is the service effective?

Our findings

At the comprehensive inspection in May 2016 we found people did not always receive effective care from staff who had the knowledge and skills needed to carry out their roles and responsibilities. Staff did not receive appropriate training, supervision and appraisal to enable them to carry out their duties. We found people's consent to care and treatment was not consistently sought in line with the MCA 2005. Where people had the capacity to consent to their care and treatment, the consent was not recorded.

From our last inspection we received an action plan telling us how improvements were to be made. This action plan stated that people's capacity to make specific decisions were to be assessed and where appropriate a best interest decisions taken. Where requirements had been given around training, the action plan stated that "all staff are to undertake mandatory training as per their role, which included Incident reporting and recording, record keeping, Safeguarding, Manual handling and Mental Capacity Act (MCA).

At this inspection people told us the staff were skilled and knew how to meet their needs. One person said "staff are very good, dedicated and helpful", "they know enough about me" "very professional" "staff are approachable – some more than others". Another person said "very good. Haven't found anything that I don't like yet".

New staff had completed an induction pack and some e-learning modules. They said they were undertaking "shadow shifts" in order to get to know the people using the service and their routines. They said they had not received any "hands on" training yet, for example manual handling training and we saw that they did not take part in manual handling procedures because of this.

The training matrix included the types of training set as essential by the provider for staff to attend. Essential training included safeguarding of vulnerable adults, Mental Capacity Act 2005 (MCA), infection control, Nutrition and Hydrations. Although the new staff member was unsure of the frequency of supervision sessions, another member of staff confirmed they took place regularly. They said "I had supervision last week. I think I have them every month".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People living at the service had capacity to make all decisions. The people we spoke with told us who helped them make decisions should they need support. One person said "My daughter is always involved in any decisions". Another person said "[staff] don't ask what I want to do – [they] think they know what I want"

The dining room was pleasant, spacious and light. There were circular tables to seat four with flowers and menus on all tables. The comments from people included "I'm not a gourmet. It's fine for me", "I choose to

have my meals in my own room. There is a good choice [I] have to choose the day before" and "Sometimes they get it wrong- if they make a mistake they will alter it quickly".

People ate their lunch in their bedrooms by choice. We saw and heard people being offered regular drinks throughout the day. At lunchtime, we overheard staff asking people "Would you like some more?" and "Is that pudding nice?"

People had access to healthcare services. Records showed that people saw their GP, the chiropodist, the audiologist and the physiotherapist for example.

Is the service caring?

Our findings

People knew staff well and there was good interactions observed between them. Staff were very vigilant of people in the communal areas and people were not left on their own, there was always a member of staff within earshot at all times. Staff responded quickly to people's needs and requests in the communal areas.

People were treated with kindness and compassion. We observed positive interactions between staff and people. We observed that on Fountain Place, due to the high ratio of staff to people, that staff had time to sit and talk with people. There was a pleasant and friendly atmosphere. It was unhurried.

One member of staff said "The care is really good here" and "The team are really good now. I would recommend it here now – but not before". Other staff comments included "Everything is good here; it has a lovely feel about it. I absolutely think people get good care here".

Comments made by people included "I am happy with the care from staff. They wouldn't be doing this work if they weren't caring". Staff were constantly asking people if they were happy/ comfortable/ warm or thirsty. Fluids were offered throughout the day. For example, staff would ask people "are you ok? Are you warm enough"? Where people asked for refreshments staff offered a range of drinks.

There were several thank you cards on display on the notice board. Relatives wrote to the staff and complimented them on the care and treatment delivered to their family member while living at the home. Their comments included the all staff had shown kindness to their relative and the family members. Where able, people were involved in care plan reviews. When this wasn't possible, we saw that people's relatives and advocates were involved and communicated with regularly. Documentation showed that staff informed relatives of any changes in people's condition, and feedback after a GP review.

People were treated with dignity and respect. Staff understood how to maintain people's dignity. Comments from staff included "I always knock on people's doors, close the curtains" and "tell people what I'm doing and why. I treat people how I would like to be treated".

Care plans contained instructions in relation to people's end of life wishes. For example, the plans detailed where the person would prefer to receive their end of life care, any funeral director arrangements and names of who should be contacted.

Is the service responsive?

Our findings

At the comprehensive inspection in May 2016 we found care and treatment was not always planned to ensure people's needs were met. People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. We received monthly audits telling us how the service was meeting this standard, the improvements made and where standards were not fully met the action on how they were to be met. The timescale for care planning was ongoing, care plans were audited and training had taken place on developing the care plans.

While there were improvements we could not improve the rating to good because to do so requires consistent good practice over time. We will review the rating at the next inspection at the next comprehensive inspection to ensure the service had remained consistent in their improvement.

At this inspection people we asked about being involved in their care plans were not certain that they had been asked or said they could not remember.

Care plans were person centred and had been regularly reviewed. They contained lifestyle profiles with people's preferred routines documented. For example, in one plan it had been documented "Likes a cup of tea early in the morning" and in another "Likes to watch TV with company". Particular preferences in relation to television programmes and preferred time to get up and go to bed were also documented. The plans also contained life history profiles detailing people's lives before they moved to Fountain Place. People's preferences in relation to male or female care staff was also documented if they had expressed a preference.

Staff knew people's needs well. There were summaries of people's needs in folders in their rooms so staff who may be unfamiliar with people's preferences, could access the information easily. When we spoke with staff they said they had read the care plans and through conversation, it was apparent that they knew people well.

Care was provided in accordance with people's needs. For example, when people had been assessed as at risk of pressure sores, there were skin integrity plans in place that detailed how staff should reduce the risk. When required, people had air mattresses in situ and these were at the correct setting. Positional change charts showed that people had support with repositioning in accordance with their care plan.

One person had a visual impairment and the care plan informed staff to "place food and drink directly in front of (person' name)" and "explain what it is". We observed that staff followed this guidance.

There was a complaints procedure in place. We looked at the complaints log for the previous two months and saw that complaints had been investigated and generally resolved.

People were aware of residents meetings held, but had not attended one recently. Due to the low number of people using the service, there had been no resident meetings. The manager explained that instead they spoke regularly to people and asked for their feedback. We also saw that people were asked for their

feedback during care reviews. A meeting for relatives had been held during January 2017, where relatives had been asked for feedback.

People we spoke with said they had no reason to make a complaint and had never done so in the past. One person told us the "Noise from the building work, they should take account of people wanting to be quiet after lunch. They should ask if it's alright to carry on".

There were activity timetables on display on the noticeboards. Comments made from people included "I read a lot. [I am] interested in painting" "[I] have the Radio Times so I can mark on the timetable what I want to watch".

Is the service well-led?

Our findings

At the comprehensive inspection on May 2016 we found that there was a lack of quality auditing and governance processes which we judged as Inadequate. We found the lack of clear quality auditing process had not informed the senior management team including members of the board and nominated individual of concerns including those we identified during the inspection. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous Care Quality Commission inspection reports and to prevent the reoccurrence of issues. We took enforcement action and imposed conditions on the registration. The provider was told to undertake monthly audits and provide the Care Quality Commission with a report which confirmed the dates on which these audits had taken place and the action taken or to be taken as a result of these audits.

We have received monthly audits in line with the condition impose of the providers registration. The audits have told us how the service was meeting the expected standards, the improvements made and where standards were not fully met the action on how they were to be met. The action plan for the service included the dining experience for people, care planning and the environment. For example, the timescale for care planning was ongoing, care plans were audited and training had taken place on developing the care plans.

At this inspection regular audits had been undertaken. These included Quarterly Whole Home audits, infection control audits and care plan audits. When issues had been noted, actions had been taken. For example, tables in dining rooms were now laid with new napkins in order to make the environment more inviting. Audits had also been undertaken of people's weights and these showed that concerns about people's weights were reviewed and that action was taken, such as ensuring that referrals for external advice had been sought.

Staff said there was an open culture. All were aware of the changes that had been implemented and they gave positive feedback. Comments included "Everything has changed for the better. The food is better, the activities are better" and "I have seen lots of improvements. Training for staff has improved, we have internal quality assurance inspections, and much better communication". In addition staff said morale was "Quite high, but staff are still a bit nervous about this report" and "Morale is good – before there was too much gossip. It's a really nice place now".

A registered manager was in post. Staff gave positive feedback about the new registered manager who became registered with CQC in March 2017. They said "I'm happy for the first time with the new [registered] manager. She is very professional. Before, we had no leadership" and "The new manager is very supportive and is very visible".

The registered manager told us a monthly log of "slips, trips and falls" was maintained and each incident was discussed with the unit manager. They said the purpose of the discussion was to identify risks to prevent further reoccurrences. It was also stated there were no trends of patterns from the investigation of incidents. Where people were falling frequently referrals had been made to the falls team.

We discussed the high turnover of staff with the registered manager. They told us some staff had been supported with their personal development and had left the service and there was an ongoing recruitment of staff. The registered manager said mentoring was to be introduced for new staff. The mentor [experienced staff] was to be matched to the new staff to help them integrate.

Surveys were being used to seek the views of relatives about the quality of service provided. The registered manager said questionnaires had been sent to gain feedback about the décor, activities and how staff greeted people. People told us that there were residents meetings but they had not attended one recently. People were unsure of who the registered manager was.

Regular staff meetings had taken place and we saw the minutes of these. In addition, we looked at Heads of Unit meetings and Unit meetings.