Avonpark Village (Care Homes) Limited

Fountain Place Nursing Home

Inspection report

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Bath
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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

The inspection visit to Fountain Place was unannounced on the 7 July 2015. At the previous visit we found breaches of Regulation 9 Care and Welfare of people who use services and Regulation 12 Cleanliness and infection control of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2010. These regulations correspond with Regulations 9 and 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider said they would take action to address the breaches of regulations.

At this inspection we found there were improvements with infection control systems but more improvements

Summary of findings

were needed to fully meet people needs. History has shown that this provider has not been able to maintain a consistent level of improvements and has breached regulations over time at this location.

Fountain Place is part of the Avonpark retirement village and offers accommodation with nursing care for up to 15 older people. At the time of the visit there were 10 people receiving nursing care at the home.

The registered manager was not in post. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The arrangements for staffing levels were not always appropriate to meet the needs of people. People said the staffing levels needed improving and staff said there was additional pressure placed on them during at peak periods.

The requirements of the Mental Capacity Act (MCA) 2005 were not always followed by the staff. Records showed the staff had a lack of understanding on who were the most appropriate decision makers for best interest decisions. Where people were resistive to personal care staff were not given detailed guidance on how to deliver care in the least restrictive manner.

People may not receive the care and treatment necessary to meet their current needs. Care plans were not updated following evaluations and reviews. People were not supported to follow their interest and hobbies.

Procedures in place ensured staff had the guidance needed to identify and report abuse. Members of staff knew the signs on abuse and the expectations on them to report suspected abuse. People felt safe living at the home.

Risk management systems in place ensured where risk to people's health, safety and wellbeing was identified action plans were developed to appropriately manage these.

New staff received an induction when they started work at the home. Staff attended the training needed to meet the needs of people living at the home. One to one meetings to discuss performance, concerns and personal development took place regularly with the manager.

People received care and treatment that was personalised and respected their rights. Members of staff knew people's preferences and ensured care and treatment was provided in a dignified manner. People at the end of their life received compassionate care from the staff.

The Complaints procedure described to people how to raise complaints and concerns. People's concerns and complaints were taken seriously and acted upon. Members of staff knew how to respond to people who raised concerns.

Systems were in place to gather people's views about the quality of the care provided. The leadership from the manager was approachable and fair. Members of staff worked well together and they were informed about changes.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Sufficient numbers of staff were not deployed during peak periods to fully meet people's needs.

Safeguarding processes and procedures in place ensured staff were able to identify the signs of abuse and were clear on the expectations placed on them to report suspected abuse.

Safe systems of medicine management were in place. People were protected from the risk of unsafe medicine administration.

Risk management systems in place ensured action plans were developed were risks were identified.

Is the service effective?

Requires Improvement

This service was not effective.

The provisions of the Mental Capacity Act (MCA) 2005 were not appropriately used to identify the most appropriate decision maker for best interest decisions. Members of staff were not provided with detailed guidance on how to deliver care using the least restrictive option to people who lacked capacity.

People were supported to maintain a balanced diet. However, they said the variety of the meals needed improving.

Members of staff receive an induction when they started work at the home. Training was provided to ensure staff had the skills and knowledge needed to meet people's needs.

Is the service caring?

Good

This service was caring.

People received care and treatment that was dignified and personalised. Members of staff knew how people liked their care to be delivered.

People at the end of their life received care and treatment to manage their symptoms and delivered in a compassionate way by the staff.

Is the service responsive?

Requires Improvement

This service was not responsive.

Care plans were not updated following evaluation and reviews of needs. People may not be receiving care and treatment which met their current needs. People were not supported to pursue their hobbies and interests.

People knew who to approach with complaints. Members of staff took concerns and complaints seriously and passed them to the manager for investigation.

Summary of findings

Is the service well-led?

Good

This service was well led.

There has been a period of instability with changes of managers.

The views of people about the quality of care were gathered through individual and group meetings and by surveys. However, people said the meetings were not consistently held.

Working relationships between staff were good and the manager's leadership style created a culture of trust and openness.

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 took place on 7 July 2015 and was unannounced.

The inspection was completed by one inspector and an 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with two people who used the service, two relatives, the registered manager, area manager, deputy manager and five members of staff. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for six people. We also looked at records about the management of the service.

Good

Is the service safe?

Our findings

People told us the staffing levels needed improving. One person said “we really do need one more member of staff here. At night time, we have one registered nurse and just one carer, often an agency staff member. We could always do with help [volunteer] everyday to give fluids.” Another person said “I don’t think they have enough staff, they have cut down recently. They are under-staffed and you have to wait, but they do come eventually.” A relative said contacting the staff by phone was difficult in particular at weekends.

The staffing levels were not managed appropriately during peak periods. Staff said there was a heavy reliance on agency staff. They said the same agency staff were used to maintain consistency of care to people. Staff had a good understanding on how the staffing levels were assessed. A member of staff explained the deployment of staff. Another member of staff said the staffing levels reflected the number of people accommodated. The third member of staff said there was additional pressure on staffing when they had to serve meals as well as helping people to eat their meals.

Safeguarding arrangements ensured people were protected from abuse. One person said “I feel safe now that my buzzer works.” Another person said they felt safe when they were being moved and handled by the staff. Members of staff attended safeguarding vulnerable adults training. The staff said the training attended and procedures in place helped them recognise the signs of abuse and informed them of the process for reporting suspected abuse. They told us it was their duty to report their suspicions of abuse.

Systems were in place to manage risk appropriately. Risks to people’s safety and health were assessed and action plans were developed to lower the level of risk. Risk assessments were devised for people assessed at risk of developing pressure ulcers and malnutrition and for people at risk of falls or with mobility needs. Risk assessments were reviewed and updated where there were changes in people’s health and their safety. Members of staff described the steps taken to reduce the level of risk to people. For example, for people at risk of pressure sores, the staff monitored their skin condition to identify signs of tissue damage.

Contingency plans for responding to emergencies were in place. Fire risk assessments were developed to determine the hazards from a fire and action plans were developed to lower the potential of a fire from happening. For example, checks of equipment and evacuation practices ensured people's safety in the home. Personal evacuation plans were in place which included information on the support people needed from emergency services to safely evacuate the property.

There were safe systems of medicine management. People told us the staff administered their medicines. One person said “the nurse gives me my medication on my tray and I take it myself. If I leave it on the tray, they ask me why I haven’t taken it.”

Medicines were administered from a monitored dosage system and the registered nurses signed the medication administration record MAR charts to show the medicine administered. Protocols were in place for medicines to be taken when required. The protocols included the purpose of the medicines, the directions and the maximum dose to be administered in 24 hours. For example, diazepam.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 assessments for people with cognitive impairments lacked the legal framework needed for staff to make best interest decisions. Records showed there was a lack of understanding in staff's roles when making best interest decisions. For example, the most appropriate decision-maker for specific decisions. By seeking the consent from relatives with lasting power of attorney, people may be placed at risk of harm if relatives were not available to make best interest decisions. for example, using bed sides.

Where people were resistive to personal care the action plans lacked detail on how this care was to be delivered using least restrictive measures. The mental capacity assessment for one person stated "at times staff need to assist XX with this task. This is all done in his best interest." However, clear strategies were not in place for staff to follow when people were resistive to personal care.

Staff knew how to enable people to make decisions about their daily living. They said people at the home made day to day decisions and meetings with healthcare professionals were held to support people with making more complex decisions. For example, Do Not Attempt Cardio Pulmonary Resuscitation (DNARCPR). Where people had capacity to make decisions they were supported by their relatives and GP to make decisions on the emergency treatment to be provided in the event of cardiac arrest.

People's consent was gained by staff before they were offered support with personal care. They said the staff always proceeded to care for them when it was "mutually convenient."

New staff received an induction which prepared them for the role they were employed to perform. A member of staff said their induction happened in the first three weeks of employment and included shadowing of more experienced staff. They said the induction was an introduction to the Skills for Care Certificate Standard.

Staff attended training required by the provider to develop their skills and knowledge needed to meet people's needs. Staff said the training was good and there were opportunities to gain professional qualifications. For example, vocational qualification . A member of the housekeeping staff told us they had access to all the training available and had recently attended End of Life training. Staff had opportunities during one to one meetings with their manager to discuss concerns, performance and training needs .

The meals and refreshments served were adequate to meet people's nutritional and hydration needs. However, people said the food needed improving. One person said "they offer me breakfast. Some people have bacon and egg, but I normally have porridge" and "they know me and they know I like porridge everyday. If I wanted something else, I could have it. The staff know I like chicken or fish and one or other is usually on the menu for me. The puddings are ok, I am not sure if the food is fresh or not, but it is tasty." Another person said "the food is ok. I get tired of soup and sandwiches very often. Wish we could have more potatoes, sausages mashed potato and onions." We made the manager aware of the comments made by people about the variety of meals. The manager said they were unaware of people's dissatisfaction with the meals as the quality assurance survey feedback about the food from people was positive.

People were given a choice of meals at each mealtime. The staff asked people to select their preferred meal for the following day. Each table had the day's menu on display and listed were the choices of meals with the alternative menu for people who did not like the choice of meals.

Suitable arrangements were in place for people to receive ongoing support from healthcare professionals. One person said there was a new GP which "looks encouraging and I think comes once a week. There is also a chiropodist which my relative makes appointments for me." Members of staff said there were routine visits from the GP twice weekly. A member of staff said there were good working relationships from the patient liaison nurse practitioner. A record of the healthcare professional visits were maintained which described the nature of the visit and the outcome of the visit. For example, medicines were changed following a medicine review.

Good

Is the service caring?

Our findings

The support people received from staff was respectful and preserved their rights. We observed staff approach people in a kind and respectful manner. For example, staff consulted with people before undertaking tasks and addressed them by their preferred names. For some people we saw staff used their title. There was a calm atmosphere in the home and the staff were compassionate towards people and their visitors. One relative said “the nurses here are excellent, they treat [the person] with great dignity and care. They ring me as soon as anything goes wrong, I cannot fault them, they are so kind, just wonderful. There is a young apprentice who is super.”

People were able to express their views about their care and treatment. A relative said the staff had updated their family members care plan when it was mentioned the care plan needed reviewing. One person said they thought the staff were “up to date with their care.” Records of the contact staff had with family members were maintained. We saw records of the comments and suggestion made by relatives and when they were informed about important events.

Staff knew to provide a caring environment it was important to build relationships with people. One member of staff said good communication and knowing when to give people time to avoid anxiety was important. For example, recognising the signs when people no longer wanted to be sociable. Another member of staff said a friendly manner and getting to know people’s background histories ensured they built positive relationships.

People were respected by the staff. One person said they were “treated with dignity and care" and the staff "were compassionate and kind.” Staff gave us examples on how they respected people’s rights. One member of staff said they explained to people the tasks they were to undertake.

People received compassionate care at the end of their life. Staff said they received End of Life training to ensure people on this pathway received care that was dignified. They had sensitive conversations regarding arrangements for End of Life with people. People’s wishes in the event of cardiac arrest was sought and appropriate forms were signed. Records showed the care provided focused on the management of symptoms and most prevalent for End of Life care. For example, pain management medicines.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not updated following the review and evaluation of the assessed needs. For example, a care plan dated 5 October 2012 said the person was independent with personal care. The evaluation report dated 8 May 2015 stated the person needed assistance from staff. Some care plans gave staff conflicting information. For example, the personal care plan for one person directed staff to check the person's skin integrity three times daily but the tissue viability care plan was not updated. This meant people may be at risk of unsafe care and treatment as staff may not be meeting people's needs. The deputy manager told us in future care plans would be re-written following the annual review.

People were not supported to follow their interests, hobbies and to take part in activities. One person said "there are no activities which I participate in; I don't know what they are. I have no activity list in my room. If I pestered the activity bloke he might take me to the pub, he keeps saying he will, but it hasn't happened so far. I only go out with my relative, [not with staff]." Another person told us "I don't know what activities are going on." A relative said "They need to get activities – Music with Movement. Before, everyone was alive in their wheelchairs. Now the activities are intermittent, they need to be permanent. We raise things at meetings about activities, but hardly ever see any". We discussed the lack of an activities programme with the manager and we were told this was being addressed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's needs were assessed before they moved to the home. Risk assessments and care plans were developed to identify people's needs. Care plans described people's preferences and preferred routines. They provided background information on the person ability and the support needed from the staff to meet their needs. For example, XX likes to have a wash after breakfast. No preference on gender of staff to deliver personal care was documented.

People received care and treatment that focused on their preferences and preferred routines. One person said they were able to choose the gender of the staff who provided their personal care. They said "you can ask for a male or female carer and that is respected. If I ask for a woman, I wait and they come. You may have to wait a bit longer, but they do come." "I also ask for a china tea pot, cup and saucer that my relative gave me. They always bring my tea in that and wash the cup and saucer by hand. They have not chipped them in two years" A member of staff said "we ask people what they want and what they like. For example, we ask XX do you want to get up and XX may say 'no I am happy in my bed' and we leave XX in bed."

Staff were kept informed on people's daily needs during handovers. They said the care plans were developed by the registered nurse. One member of staff said they read the care plans. Another member of staff said it was the care assistant's responsibility to maintain the daily life reports. Individual daily life reports described the activities undertaken by people and who had visited them.

Systems were in place to manage complaints and concerns. A relative said "as far as complaints are concerned, I would complain if need be – I haven't seen a complaints form, but I am sure there is one somewhere. I have never complained myself." One member of staff said people were encouraged to raise concerns, they offered an apology to people when concerns were raised and their concerns were passed to the manager for investigation. There were no complaints received at the home from people or their relatives since the last inspection.

Good

Is the service well-led?

Our findings

There has been a period of instability with changes in managers. The registered manager cancelled their registration as manager in 2013 and since then two mangers were appointed. A manager was recently appointed.

Members of staff worked well together and had confidence in the manager. Staff said the manager was approachable and fair. One member of staff told us a deputy manager was recently appointed and they worked well with the manager. Another member of staff said the manager was genuine and they were kept informed about changes in the running of the home.

Systems to gather and evaluate information gathered from people about the service were in place. However, people's views were not consistently sought. A relative said "The reviews should be every six months, but they don't happen. I think there have been two in the last year." However, there is no continuity [of the meetings]. I think things are improving though." Another relative said there were meetings with the new manager and intermittent reviews of their family member's care. The manger told us the relatives meeting were three per year. The views of people and their relatives about the service were sought using surveys. The manager told us surveys were sent and analysed by the staff at head office. They said there was an expectation on the manager to devise an action plans from the comments and suggestions made through the surveys.

Systems and processes were in place to assess, monitor and improve the quality, safety and welfare of people. There were effective systems of auditing which ensured people received appropriate care and treatment. The system of audits included medicine management, falls and infection control for the spread of infection. The deputy manager told us the care plan audit had identified care planning systems needed improving. For example, care plans were to be rewritten following reviews and a one page summary were being developed to help agency staff with getting to know people's current needs.

The manager told us monthly reports were developed monthly for the area manager on areas of risk, complaints received and admission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not updated following monthly evaluations and review meetings. Staff were not provided with an up to date action plan which reflects people's current needs.