Fountain Lodge Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20 September 2016 and was unannounced. Fountain Lodge Care Home Limited is registered to provide nursing care for up to 30 older people. At the time of our inspection there were 25 people living in the home.

During our last inspection on 24 March 2015, we found the provider was not fully meeting the standards required. This meant we allocated an overall rating of "Requires Improvement". During this inspection we found there continued to be areas needing improvement.

There was a new registered manager in post who registered with us in September 2016, shortly prior to our inspection. 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. The registered manager was not available during our visit due to being on leave.

People told us they felt safe living at the home. The provider carried out a range of recruitment checks but records were not always clear to show staff employed were safe and suitable to work with people. We found some improvements were required to how risks were managed to ensure the ongoing safety of people in the home. This included risks associated with the use of specialist equipment. There were also some areas of risk in relation to medicine management that required improvement.

There were sufficient numbers of staff employed to meet people's needs. Staff completed training on an ongoing basis to help them develop their skills and competence to carry out their role safely and effectively. However, there were some gaps in staff training that needed to be addressed.

Staff had some understanding of the Mental Capacity Act. The manager had ensured applications to the supervisory body (the local authority) had been made where restrictions had been placed on people's care amounting to a deprivation of their liberty.

People said they had enough to eat and drink and there were meal choices provided each day. Where people were at risk of poor health, due to not eating or drinking enough, there were processes to monitor their food and fluid intake to help ensure their nutritional needs were met.

Visitors were made to feel welcome at the home at any time to help people maintain relationships with people important to them. There were minimal social activities provided to support people's hobbies and interests. The atmosphere in the home was quiet and relaxed with staff interactions usually only when there were care tasks to be completed. However, individual staff members were caring towards people and we saw that staff were mindful of protecting people's privacy and dignity.

Each person had a care plan which contained the information staff needed to meet people's care needs. These were being reviewed to ensure they provided staff with more detailed information about people's needs and preferences to help deliver more person centred care.

There were systems to monitor the quality of the service and drive improvement within the home but these were not consistently effective to ensure people received safe, effective care that was responsive to their needs.

Staff understood their roles and were supported by the registered manager through one to one supervision meetings and staff meetings. People and staff told us the registered manager was approachable.

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.

There were sufficient numbers of staff to keep people safe and staff understood their responsibility for reporting any concerns about people's wellbeing. There were some practices associated with medicines management that needed to be improved. Risks associated with people's care were not always effectively managed to ensure people's ongoing health and wellbeing. Recruitment records were not always clear to confirm safe processes had been followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed training on an ongoing basis to help ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and supported people to make their own decisions where possible. Where restrictions on people's liberty had been identified, appropriate applications had been made to the supervisory body. People were supported to attend appointments with external healthcare professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were supported by staff who were overall caring in their approach. Staff respected people's privacy and dignity, and promoted their independence where possible. People were supported to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive person centred care that met their needs and preferences. Care plans were being developed to

ensure they centred on the needs of individuals so staff had the information they needed to provide person centred care. Relatives had some involvement in making decisions about people's care and staff respected their views. People's social needs were not always supported to help maintain their health and wellbeing.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were mostly positive in their comments of the service but we found processes and systems were not fully effective in ensuring the quality of service was always maintained. Staff were mostly positive about working at the home.

Fountain Lodge Care Home Limited

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 20 September 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist nurse advisor.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioning officer to find out their views of the service. The information they shared was similar to what we knew about the service. We looked at the last visit report completed by Healthwatch so that we could see if any of their recommendations had been implemented.

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. This however, contained limited information in respect of the information we requested.

We spoke with three people who lived at the home, three relatives, two care staff, the deputy manager and a nurse. We observed the care provided to people and reviewed the care plans of three people in detail. We also reviewed other records to demonstrate the provider monitored the quality of service such as staff meeting minutes, staff training plans, quality monitoring questionnaires, audit checks, accident and incident records, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Fountain Lodge and relatives also supported this view. One relative told us, "I think [person] is safe. They take really good care of [person]."

Staff felt people were safe in the home. One staff member said, "They are safe because we look after them properly." Another staff member told us, "We make sure things are in place to stop people getting injured like falling. We maintain a safe environment and make sure the residents are watched over and looked after properly. Everyone is very good here to the residents."

Staff understood about the different types of abuse and staff behaviours that could be seen as abuse, such as staff refusing or failing to provide appropriate care. For example, one staff member told us, "There are four types of abuse – physical, mental, sexual and financial. If I refused to change a person's pad that is physical abuse." Another staff member told us, "People neglecting the residents. Mental, physical, intellectual and emotional abuse." Staff knew to report any concerns that someone may be abused to the person in charge which demonstrated they understood their responsibility to maintain people's safety and wellbeing. However, staff did not understand what action the registered manager would take and who they reported the concerns to outside the home. This meant they may not recognise when appropriate action had not been taken so they could escalate concerns further.

There was a 'whistle blowing policy' staff could refer to if they felt the need to report any concerns that had not been addressed by the registered manager or provider. This was displayed in the entrance to home. However, when we asked one staff member about the policy it was clear they did not know what this policy was for, suggesting staff may need to be reminded of this.

Risks to people's safety had been identified and assessed and care plans we looked at contained risk management plans for staff to follow to keep people safe. These included plans about how to support people who had limited mobility or plans to support people's pressure relief so they did not develop sore areas on their skin. Where people needed support to mobilise safely, plans were in place which detailed any equipment that should be used as well as the number of staff needed to move or transfer the person safely.

We observed that staff followed instructions in care plans when supporting people. For example, we saw staff transferring people using a hoist and this was always done with two care staff to ensure it was done safely. One staff member said they always checked equipment before they used it to make sure it was safe for people. They told us, "We make sure the hoist is safe to use. Before we hoist them we make sure the straps are on the right way." Another staff member told us that equipment in the home was well maintained.

We noted that a number of people who were supported with a hoist were sitting in their wheelchairs or lying in bed on the slings that were used when they were hoisted. A relative told us that their family member frequently was left sitting on the sling. We asked staff about the slings and if it was safe for the slings to be used in this way as sometimes this practice can compromise people's skin care and pressure relief. We could not determine this information from speaking with staff to be sure this was safe practice. We asked

them to check this with a health professional.

During the last inspection we identified that the settings on pressure mattresses provided for people who were at risk of their skin breaking down were not checked regularly by the registered nurses. We identified during this inspection that six of the specialist mattresses we checked had been placed on the highest setting and not settings appropriate for the person's weight and skin management. We spoke with the deputy manager about this and identified when mattresses had been placed at the 'correct' settings this had resulted in people developing red areas on their skin. There was a concern that the pumps connected to the mattresses may not be working effectively. The deputy manager had stated that to manage the risk of people's skin not breaking down the mattresses had been placed at the higher settings. However we could not be assured these were correct and safe for people.

Staff told us they checked people's skin regularly and recorded any marks or bruises on people's skin and made the senior on shift aware. One staff member told us, "Every day we check the skin of residents for any bruise or mark. I would write it on the body map and inform the nurse in charge." We looked at the care records for one person who was at risk of developing pressure sores. Daily records showed staff had recorded when the person's skin was red and creams had been commenced and applied daily to manage this and prevent the sore areas from deteriorating further. We also noted that accident and incident forms had been completed for bruises and skin tears showing they had been identified and acted upon. Staff had completed training in skin care to minimise the risks of people developing more serious skin conditions such as pressure sores.

We found staff had not managed the risks associated with skin care for one person. During our visit we found a person in bed in need of personal care. There was a strong odour coming from the person's room and the door to their bedroom was left open. Despite this, staff did not notice or attend to the person in a timely way. This was also confirmed when we viewed the person's records. We raised this issue with the deputy manager who advised all staff would be spoken with to help prevent this from happening again. They also said this would be reported to the registered manager on their return.

People told us that overall, staff were around when they needed them and if they used the call bell staff responded within an acceptable amount of time. However, they felt that at times the home was "short" of staff. One person told us, "They get short staffed but they get on with the job." A relative told us, "I wonder sometimes if they are a bit short, they could do with more." When we asked them if their family member had to wait for any length of time to be assisted they told us "not often." Another relative told us, "Sometimes I think they could do with more but most of the time it is alright. When they are very busy they could do with more. It is consistent staff." We observed that staff were very task orientated in that they had limited time to speak with people, but people's basic needs were met by the numbers of staff on duty.

Staff felt there were enough of them to meet people's needs. One person pressed their call bell when we were in their room and a staff member responded immediately. One staff member told us, "There are more [staff] now but before when I started here there didn't seem to be a lot." They went on to say there were normally six staff on duty, three upstairs and three downstairs. Staff told us that sometimes there were only five care staff providing care because there was no activities co-ordinator and the sixth carried out activities with people.

One staff member raised a concern that there was only one senior care staff member employed by the provider which meant there was not always a senior care staff member on shift. They said they had raised this with the registered manager and they had stated another senior care staff member was going to be employed. Staff told us there was always a nurse on duty to support people's nursing needs and it was a

permanent nurse. Duty rotas confirmed this.

Emergency information was available in the entrance to the home. This included information about what assistance each person required to evacuate the home safely and the business emergency plan with contact numbers of suppliers to be contacted in the event of an interruption in services to the home such as gas and electricity.

The provider had a recruitment procedure that required a number of checks to be completed to ensure prospective staff were of good character before they were employed to work at the home. However records were not clearly organised to confirm the procedure had been followed. We looked at two recruitment files. We noted one staff member had started work before their Disclosure and Barring Service (DBS) check had been obtained. However, there was a signed declaration of no convictions and a note stating that a condition of their employment was that they would be under the supervision of the senior care assistant until the DBS check was in place. The DBS is a national agency that keeps records of criminal convictions. There were two written references on the person's file but these were not dated to confirm these had been obtained before the person started work so that the provider could assure themselves the person was of a good character. The references from the person's previous employer had no validating stamp to confirm it was received from them. We spoke with the staff member to confirm what happened when they were employed. They told us they had not worked alone when they started and had not provided personal care to anyone until their employment information checks had been received by the registered manager. They said, "I was observing. I didn't do a lot because I was waiting for the Criminal Records Bureau (same check as DBS). I assisted with feeding and making cups of tea."

People told us they received their medicines as required. One person who was taking pain relief medicines told us they were in no pain, demonstrating their medicines were managed appropriately. We noted that one person had been prescribed a medicine that could cause a rise in their blood pressure. Due to the person's health and the side effects of the medicine, it was important their blood pressure was monitored carefully prior to the administration of this medicine. We did not see that this happened. When we spoke with the nurse on duty they seemed unaware of the importance of this.

We saw that monthly checks were undertaken of people's blood pressure to identify any changes in health but it was not always clear if action had been taken in response to the results. For example, one person's blood pressure showed a reading that was outside of normal ranges but had not been rechecked to see if it was an error in the reading or if there was a concern regarding their health. This was subsequently reported to the registered manager so that any concerns regarding blood pressure checks could be identified and acted upon.

Medicines were stored securely and in line with current guidance. This included those medicines kept in the fridge such as eye drops and Insulin which were labelled with the date of opening so that it was clear to the nurses when they needed to be disposed of.

People were supported to take their medicines safely. Medicine administration records (MAR's) contained a recent photograph of each person to help ensure staff administered medicines to the correct person. Allergies were clearly labelled on the MAR's and these medicines had not been prescribed for these people. The nurse confirmed there was always a second person to check the administration of those medicines which required extra care in accordance with the provider's policy. During out last inspection not all care staff who were assisting the nurse had been trained about these medicines. We saw that staff had completed basic training in medicines but records did not show this included the medicines that required extra care and the deputy manager was not able to confirm this. The nurse told us "Not all carers have had

training but there is always someone to ask." We asked the deputy manager to check that staff assisting the nurse were fully trained in safe procedures for the medicine administration.

We noted that the way some medicines were disposed of was not safe. The container (denaturing kit) used to dispose of medicines, which required extra care due to their strength, was found to be full to the top with glass vials still holding the medicine within them. The purpose of a denaturing kit was to render the medicine unusable for use and we were able to remove the vials. There were also sharps (needles) in the container. A safer method of disposal is to withdraw the liquid and put the liquid in the 'denaturing' solution and then dispose of the sharps in a locked sharps bin. We raised this issue with the nurse on duty as well as asking about medicines that were to be returned and how they would fit into the sharps container. The response we received raised concerns about safe medicine disposal in the home.

We were told by the nurse that one person received 'covert' (medicine disguised in food) medicine. We found there was no formal covert medication authorisation and it wasn't mentioned within the MARS file or care file. The provider's medication policy stated, "If you administer medication covertly or encourage someone to do so this is an act of gross misconduct and you may be dismissed." It therefore appeared the medicine policy was not being followed.

There was a PRN protocol (relating to medicines to be given as required) for medicines such as pain relief or anxiety. We saw the protocol gave staff clear information about the use of medicines to be given in this way and they were not being used excessively for those people we checked. We noted when reading one person's care records they had been prescribed two different types of pain relief medicine to be given PRN. Daily records showed one of these was not available to give when the person needed it. This had not been identified as part of the medication checks and it was recorded in other daily records that the one medicine on its own was not effective. This meant the person's pain relief had not been effectively managed.

Requires Improvement

Is the service effective?

Our findings

We asked people and relatives if they felt the staff that supported people were sufficiently trained and knew what they were doing. Comments included, "Some are better than others, they seem to be mostly able to do what they need to do" and "What I have seen of them, they seem alright."

New staff received an induction to the home when they started work. One staff member told us this took two days and included, "Fire points and how to care for patients." Staff told us they had completed ongoing training to help them carry out their roles safely, and were encouraged to update this regularly and pursue nationally recognised qualifications to support their practice. However, when we looked at training records we saw there were gaps in training for some staff which meant they may not always carry out their duties safely and effectively. This included moving and handling people training. The registered manager had identified this as we saw a notice to staff advising them they must attend training planned.

Staff had not received training regarding specific health needs such as catheter care but were able to tell us about the signs they should look for which might suggest the person had an infection. They were also aware of checking the drainage into the catheter bags and the tubes to make sure they were not blocked. However, one care staff member was asked why a person in the lounge was sitting with a catheter stand and night bag attached as opposed to a day bag. The day bags are usually attached to the person and are more discreet. The care staff member was not able to understand what we were asking to respond to ensure the issue was dealt with. Action was taken during our visit for the bag to be changed.

Staff told us they felt supported and had opportunities to meet with the manager to discuss their work through supervision meetings. One new member of staff member that had been at the home for several months told us, "I have had one or two (supervisions) since I have been here."

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that there had been several DoLS applications made in relation to people in the home to seek authorisations as required.

Staff understood that some people needed support to make their own decisions. One staff member told us, "I will explain to the residents to help them make a decision. You have to understand them and give them choices." We asked what they would do if a person was unable to make a decision. They told us, "We would have to arrange a good decision for them based on what they are comfortable with."

Although staff had recently received training on DoLS there was a lack of clarity in their understanding of what a DoLS actually was and how it may impact on people in the home. This questioned the effectiveness of the training provided. Staff were also not aware of who had DoLS authorised which was important to make sure they delivered care in a way that had been agreed, so as not to place any unnecessary restrictions on them.

We asked a relative if staff asked for consent before delivering care to their family member. They told us, "Normally they do talk to [person] and ask if they want this or that." Staff told us they would seek support if people refused care. One staff member told us, "I would inform the person in charge of the shift and they would decide."

We saw in some care files where people had given consent there were "Do Not Attempt Resuscitation" (DNAR) orders which had been signed by health professionals. Those seen had been discussed with people or close family and there was a clear reason for the decision.

We asked people what they thought of the meals and food provided at the home. One person told us, "I had liver today and it was lovely, generally it is not so bad." Another person said, "Some is nice and some isn't nice. There is not much choice, I just eat it. I am not into food." However, we identified the person was restricted in what they could eat due to dental problems which they were awaiting to be addressed by a visiting dentist.

Menus in place were not being accurately followed to show people received varied and nutritionally balanced meals. We found some of this was due to effective arrangements not being in place to allow this to happen. For example, liver and Cornish pasties were on the menu on the day of our inspection but Cornish pasties were not available. When we checked we were told they had not been ordered. Bread and butter pudding was also on the menu but was not provided as the chef was away and kitchen staff did not know how to prepare it. One of the alternatives provided was a strawberry gateaux but this was too small to share with everyone so some had a mousse-like dessert instead.

We asked staff how they managed meals for those people who could not make their own choice. One staff member told us, "We would try it with them and if they like it we would give it them." This showed staff gave some consideration to people's likes and dislikes.

Staff were aware of people who required a soft or pureed diet. The cook told us, "We have a pureed diet and soft diet where the meat is pureed and the vegetables are soft and then normal diets." A relative told us, "It is very good because [person] has to have it all mashed up. There is plenty of it." They also told us that staff made sure their family member had plenty to drink "all the time".

Where people's health may be at risk due to them not drinking enough, staff were required to complete 'fluid' charts. We looked at the fluid charts for one person and noted drinks had consistently been recorded as 200ml which was the amount given rather than the amount consumed. We brought this to the attention of the deputy manager who said they would review this. The amounts were totalled up each night so there was a clear picture of how much the person had been given and there was evidence of people being given drinks through the night so they remained hydrated.

People's day to day healthcare needs were being met. Relatives told us family members at the home saw healthcare professionals when required such as the GP. One told us staff were "very good" at calling the GP when their family member was ill. They also told us staff let them know when their family member was unwell. We saw that people's weight was monitored and recorded monthly and where people had lost

weight they were referred to a dietician so that their advice could be sought and followed.

During our review of care plans, we saw people had access to healthcare services when a need was identified and received on-going support. We saw in one file where the person's health had deteriorated, arrangements had been made for them to see the GP who had carried out a medicine review. The person had also seen an optician, dietician and 'tissue viability' (skin care) nurse to support their healthcare needs.

Good

Is the service caring?

Our findings

We asked people and relatives for their opinion of the care provided at Fountain Lodge and the staff that provided support. They were positive in their comments. They told us, "I have found them okay." One relative said, "Oh yes very caring. The way they speak to the patients and do what they can for them."

Staff told us they felt they were caring towards people and we observed this was the case. We saw when one person became anxious and started to cry, a staff member sat by them and spoke quietly to them and gave physical reassurance by stroking their hand. This helped to calm the person. They asked, "Do you want a cup of tea?" They did the buttons up on the person's cardigan and spent a couple of minutes reassuring them before they continued with other duties. The staff member told us, "Sometimes [person] is low in mood and doesn't want to talk to anyone and sometimes they are crying. I will talk to [person] and they feel good and calm."

People with differing ethnicities were supported by staff who could speak their language. Staff who did not speak one person's language had learned their likes and dislikes and found other ways of communicating with them. This included them learning key words in the person's own language to help them communicate and ensure their needs were met.

One person had difficulties communicating due to their hearing and we saw staff used a notebook to communicate with them in writing so their needs were met and they did not become isolated.

Staff understood the importance of maintaining people's dignity and being respectful. They were able to describe how they delivered care to ensure this happened. One staff member told us, "If we are dressing them and giving personal care, they will be in their rooms and their door is closed." They went on to say they also ensured people's privacy was respected in the shared room. They said, "We put a little curtain across when we are changing them to respect their dignity." They commented that they wanted to make sure people were comfortable, clean and happy.

Staff responded to people's wishes and choices about their day to day needs. For example, whether they wanted to sit in the lounge or dining room or stay in their room and what drinks they wanted. One staff member told us communication was good with people. They told us, "If you haven't got good communication you can't work properly with people." Staff told us they gave people choices about how they spent their day such as if they wanted to remain in bed or be assisted to sit out in a comfortable chair. We observed one person being hoisted. Staff explained what they were going to do and spoke to the person through the process. The person appeared relaxed and staff ensured the person's legs were covered with a blanket to preserve their dignity. Another staff member explained they always explained to people what they were going to do to support their dignity and respect.

There were no restrictions on times for relatives and friends to visit people. We saw visitors come and go during the day so that people could maintain relationships with people important to them.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in March 2015 people told us they were "bored" as there was little for them to do each day. During this inspection we looked to see how people spent their day and if they were engaged in any social interaction with staff or each other or if they participated in any social activities. We found that people had limited opportunities to be socially stimulated by participating in activities of interest to them or that they enjoyed.

We observed there were a number of people in bed and staff told us most of these people could not sit out of bed or in communal areas due to them being at risk of falling. However, staff told us these people had not been referred to health professionals to determine if they would be suitable for any specialist equipment to support them out of bed. For example, assessments for specialist chairs to potentially enable them to sit with other people to reduce the risk of them becoming isolated.

One person who was cared for in bed told us, "It's alright, they don't talk to you much. They get on with the job then they are away." Although the person told us they were checked by staff regularly they stated that staff did not stop to talk to them. We found there were missed opportunities for staff to develop their knowledge about people and their preferences to support person centred care. For example, a relative told us that their family member's care needs had been discussed with them when they moved to the home but there had not been any recent discussions to ensure their ongoing involvement. A second family member told us, "No not really" when we asked them if they were involved in planning and decisions about their family member's care.

Each person had a care plan that contained information about how their needs were to be met. Staff told us they got to know about changes to people's health and people's choices through information shared at 'handover' meetings that took place at the beginning of each shift. One staff member told us, "Everyone has a care plan. When they come to the home they give a handover of what they like, what they eat and what they drink." However, we could not be confident the handover process was always effective in communicating changes to people's health. For example, care staff spoken with were not aware of the sore areas that had developed on one person's skin which indicated this information had not been shared with them.

In one care plan we saw the person experienced pain when their dressings were changed and there were instructions for staff to administer pain relief half an hour before this was done. We saw records confirming pain relief was given in accordance with the instructions to ensure the person was not placed at risk of any unnecessary pain and discomfort. There were clear wound assessments completed for each wound on every dressing change. The wound assessments were very thorough and recorded factors to avoid that could delay healing. There was a body diagram, details of the type of wound, wound dimensions, skin type and information about treatment objectives. This helped to ensure a consistent approach by nurses to managing the wound to promote healing.

The atmosphere in the home was quiet and calm and staff were busy carrying out care. Staff tended to only

interact with people when they carried out a care intervention. At breakfast time, staff listened to music of their taste in the kitchen which could be overheard in the dining room. No music was played in the dining room in accordance with people's choice and we did not see that people were asked if they wanted to listen to music. We saw one person was sat alone at a table to have their breakfast with no people or staff to talk to. When they had finished, they struggled to remove the clothes protector that staff had put on them. Staff were not available in the dining room at this time as they were busy getting people up. We ensured the person was assisted. When we walked around the home a person in bed told us they were uncomfortable, a staff member had just been in to support this person but had not checked the person was comfortable to sit up in bed before they left. We spoke with a staff member about this so that the person could be supported again.

Social activities were carried out when staff had time and were only occasionally based on people's interests. We could not see that social activities were person centred to ensure people enjoyed them. We asked relatives if there were enough social activities provided for people. One told us, "I think so, they have a go. They were singing one day and they have a ball to play with." Another told us, "No, they sit there in the lounge and are sitting there all day. Music has been blaring out; there is nothing for them to do. I often think it must be a long day sometimes."

We asked staff if they felt there were sufficient social activities provided for people. They told us, "Some days yes and some days no. The hairdresser comes in every two weeks." One staff member told us they sometimes took people to the local shops which they enjoyed but we found this was not a regular practice carried out by all staff. We noticed that people were holding clip boards and pens and asked staff about these. One staff member told us, "I have given them a writing activity to do. I have asked them to write a little bit about themselves, what they can remember. Just to give them a little exercise with their hands and with their fingers. We try, but today we have been busy. Yesterday they were writing about themselves. The day before they were throwing a ball." We saw that people sat with the clip boards for some time and some had one or two words written on them but people were not supported by staff for any length of time to help make this an enjoyable activity.

We asked staff if they had time to talk to people, one staff member told us, "Mostly downstairs in the lounge area. At dinner, when feeding people, I will talk to them." When we spoke with staff they had limited knowledge of the backgrounds, hobbies and interests that people had. This meant they could not use this information to help them in providing person centred care. Staff appeared to have a lack of understanding of how this knowledge could be used to have a positive impact on the care people received in the home.

We noticed during mealtime observations that one person who took sugar in their drink was given a drink with no sugar and they were unable to drink it suggesting some staff were not aware of people's preferences. Staff were not around all the time for the person to request some sugar but they did put some in when they came back into the dining area sometime later. When we spoke with a member of kitchen staff about people's diets and preferences they were not fully aware of these to help them ensure people's dietary needs were met.

People and relatives told us they would go to the registered manager if they had any complaints about the service. One relative told us they had not had cause to complain but if they did said, "I would have to speak to the manager." This demonstrated they had confidence in reporting any concerns to them. The provider had a complaints policy and procedure and this was displayed in the entrance hall to the home so that people and visitors could access it. Complaints records were maintained and complaints had been investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they were mostly satisfied with the care and service provided at Fountain Lodge Care Home Limited. One commented, "I think basically it is ok." Another said, "It is reasonably good ….. they listen to what I want." When we asked one relative if there was anything the service could improve, they responded, "I don't think so, they do very well."

The registered manager had previously worked at Fountain Lodge but had left for a period of time and returned. Relatives were aware of who the registered manager was and knew she was on leave at the time of our inspection, demonstrating that the registered manager communicated with people and visitors. One relative told us, "She is very good actually."

The management team consisted of the registered manager, deputy manager and nurse. Staff were mainly positive about the registered manager. We received one comment that an issue raised was not effectively dealt with. Staff told us they received guidance and advice when they needed it. One staff member told us, "She (registered manager) is very good, very understanding and very helpful to every resident. She understands the problems and is very co-operative. She is good natured." Another said, "I think she is lovely. I think she is good at most things really."

The registered manager and provider understood the requirements of their registration and their responsibilities to provide quality care and support to people. They had returned their Provider Information Return when requested although information within this was not sufficiently detailed to support the inspection process. They also understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. This included serious accidents and incidents.

The registered manager had completed an analysis of accident and incidents that had occurred in the home and had identified some people had bruising. They had taken action to respond to this information by speaking with staff about their moving and handling methods. We also saw a notice to staff that stated, "Any further bruising that cannot be accounted for will result in all staff on shift receiving disciplinary action." Staff were told it was not acceptable for people to have bruises. However, we noted from the training matrix that nine staff were recorded as not having recently completed moving and handling training to ensure they could support people safely. When we looked at the provider's arrangements for organising staff training, we found these were not effective. We were told staff were not paid for the time they attended training and we saw a poster telling staff if they did not attend training they would be made to pay for it.

Quality monitoring processes included quality questionnaires, staff and 'resident' meetings and some management checks of staff. The deputy manager told us the provider visited the home sometimes weekly and sometimes monthly to assess that people were getting the care they required. We saw people and their families had been invited to complete quality questionnaires about their experiences of the home although out of 27 questionnaires sent only seven were returned. The majority of the responses received were positive about the care delivered. Information on the results of the questionnaires was on display in the home but relatives spoken with were not aware of this. One relative confirmed they had been asked to

complete a questionnaire about the quality of the home but when asked if they had received any feedback responded, "No I don't think so." Where negative comments had been made on questionnaires we saw the manager had taken action to address some of these but we could not see they had all been effectively acted upon. For example, one comment was, "More interaction with residents instead of continual television in the lounge." We did not see this had improved.

The provider had carried out a staff survey to give them an opportunity to comment about their experience of the home. Nine out of 30 staff had responded and those that had responded were mostly very positive. Staff had stated they felt motivated and most said they had the "tools and resources" to do their jobs. Areas where they had commented negatively included some staff needing to communicate more with people and more training to be provided. An analysis of responses had been undertaken with actions to provide more training suggested the registered manager had taken the comments seriously. We asked staff how they would rate the service, One staff member said, "It isn't poor, the residents are looked after and get fed."

Although there were quality assurance systems and processes in place, it was not evident these were always effective. For example, we found that sometimes risks associated with people's care were not always managed as checks were not always made to ensure this. For example, mattress checks to make sure they were on safe settings and personal care checks to make sure people's needs had been met. Audits of medicines had not identified that disposal methods were not safe. Daily records did not contain consistent information to show care needs were being identified and met. For example, there were references to one person having "red" skin areas on one day but these were not reported on the next day to show if they remained and if continued treatment was required to prevent skin breakdown.

We saw that a staff member had completed an induction to the home but had written wrong answers to a written test but this had been 'signed off' as completed. We did not see any evidence that had been addressed with the staff member to ensure they understood an error had been made to aid their learning.

From our discussions with staff and the review of training records, we identified that staff had not completed all the essential training required to ensure they could support people safely and effectively. For example, one staff member had not completed training in how to identify abuse and safeguarding people despite working at the home for some time. This meant they may not fully understand their responsibilities on how to keep people safe.

Staff told us they attended staff meetings where they were told about issues relating to the running of the home such as following policies and procedures and completing training. The minutes of the meetings did not show that staff were given the opportunity to raise any concerns or issues or make suggestions so that they felt valued and involved in decisions. However, one staff member told us "They are helpful. The manager will tell us things we need to know or prompt us on things."

We found records within the home were not always clearly organised to demonstrate the provider's systems and processes were effective. For example, although 'Deprivation of Liberty Safeguard' referrals had been made, not all the actual authorisations were kept on files so that it was clear if there were any conditions on the authorisations that needed to be complied with. Some records were not accurate, for example in one care file it stated in one section the person's faith was "Church of England" but in another section stated it was "Catholic".

There were some areas of the environment needing attention but no clear maintenance plan or checks to show these issues had been identified. For example, the lights were not working at the top of one set of stairs on the first floor and the corridor and stairs were dimly lit which was a risk to people. In the dining

room there were three chandeliers which required six bulbs in each. In two of them, there were only three and in the third there was only two. We discussed this with the deputy manager so that the provider could address this. We noticed there were only five dining room chairs in the dining room which meant the number of people who could eat in the dining room was limited. This restricted people from being able to enjoy the social experience of mealtimes.

Other health and safety checks of the premises such as the gas and electricity had been carried out.