Avonpark Village (Care Homes) Limited

Fountain Place Nursing Home

Inspection report

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Date of inspection visit:
25 August 2016

Date of publication:
26 September 2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

At the comprehensive inspection at this service 18, 19 and 23 May 2016 we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We imposed a condition on the providers registration, issued the provider with two warning notices and seven requirements stating they must take action to address these breaches. We shared our concerns with the local authority safeguarding and commissioning teams.

This focused inspection was carried out to assess whether the provider had taken the necessary actions to meet the two warning notices we had issued. We will carry out a further unannounced comprehensive inspection to assess whether the actions taken in relation to the warning notices have been sustained, to assess whether action has been taken in relation to the seven requirement notices and to provide an overall quality rating for the service.
This report only covers our findings in relation to the warning notices we issued and we have not changed the ratings since the inspection in May 2016. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. You can read the report from our last comprehensive inspection by selecting 'all reports' links for Fountain Place on our website at www.cqc.org.uk.

At this inspection we found the provider had taken action to address the issues highlighted in the warning notices. The provider had developed a comprehensive action plan to address the warning notices and other requirements in the inspection report where they were found to be in breach of regulations.

During our last inspection we found staff were not always confident that safeguarding concerns would be listened to and acted upon. At this inspection the provider had addressed the issues with staff surrounding the reporting of safeguarding incidents. The nurse in charge informed us that instructions about informing the local authority safeguarding team about incidents had been discussed with the staff team. This information had been added to the induction for agency staff working within the service to ensure they were aware of how to report safeguarding concerns. One member of staff we spoke with said they now had confidence things would be "Dealt with appropriately" and necessary actions undertaken to deal with the situation. There had not been any new safeguarding alerts raised since our last inspection.

During our last inspection we found that whilst risks assessments had been completed the care plans did not always contain detailed information for staff on how to minimise the risks. At this inspection risks assessments had been reviewed and updated to contain guidance for staff on how to minimise the risk of harm to people.

People were sometimes cared for by agency staff who were unfamiliar with their needs. The nurse in charge explained that all agency staff now undertook a comprehensive induction. The service used the same agency staff, where possible, to ensure people received consistent care. Each person had an accessible care plan in their room which contained an overview of people's needs, the care they required and how they wished to receive this care. This meant where agency staff did not have the time to read the person's full

care plan they had access to information relating the daily care and support the person needed them to provide. Agency staff spoke positively about this information stating "The information is very helpful and acts as a quick reference of the care people need".

At our last inspection we found accidents and incidents were not always recorded appropriately and reported to the management team. As a result of this the provider had implemented a new accident/incident reporting form which was reviewed by the interim manager each month to ensure appropriate actions had been undertaken.

People's care plans had been reviewed to ensure they contained information for staff on how to prevent or minimise people's risk of distress and how to keep themselves and the people using the service safe.

During our last inspection it was not always clear if people had been supported to have sufficient to eat and drink throughout the day. The systems in place contained conflicting information regarding people's nutritional needs and monitoring forms were not always completed. During this inspection we saw charts for monitoring people's nutritional and fluid intake were available in people's rooms so staff were able to complete them as soon as the person had been supported to have any food or fluid. Agency staff had been made aware of the need to complete these monitoring forms. Records we reviewed had been completed and nutritional advice on these forms corresponded with the information in people's nutritional care plans.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found action had been taken to improve the areas of concern highlighted in the warning notices.

The process of reporting safeguarding concerns had been spoken about with staff including agency workers.

Reporting forms for accidents and incidents had been reviewed and updated to contain information relating to reporting processes and actions taken.

Quick reference information was available to all staff regarding people's care and support needs and how they wished to receive it.

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.

We undertook a focused inspection of Fountain Place Nursing Home on the 25 August 2016. This inspection was completed to ensure improvements to meet legal requirements planned by the provider after our comprehensive inspection 18, 19 and 23 May 2016 had been completed. We inspected the service against one of the five questions we ask about the services: is the service safe? This was because the service was not meeting legal requirements in relation to that question and we had issued warning notices following the comprehensive inspection. The inspection was carried out by one inspector and an inspection manager and was unannounced.

During our inspection we spoke with a visiting relative, the regional manager, interim home manager, the nurse in charge, the activities coordinator, housekeeping staff and two agency staff members. We reviewed a range of records which included four care and support plans, monitoring documents, accident and incident forms and safeguarding information. In addition we reviewed the staff training matrix and staff supervision records. We reviewed the induction and handover information agency staff received whilst working at Fountain Place Nursing Home.

Inadequate

Is the service safe?

Our findings

At the comprehensive inspection on the 18, 19 and 23 May 2016 we found staff were not always confident that any concerns raised would be listened to and acted upon.

We could find no evidence of the action taken by the management team in response to this whistleblowing.

These concerns were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we issued a warning notice to the provider. At this inspection we found the provider had made the necessary improvements to meet the shortfalls in relation to the requirements of Regulation 13.

The nurse in charge informed us that instructions about informing the local authority safeguarding team about incidents had been discussed with the staff team. Information was in place in relation to safeguarding and whistleblowing which guided staff on any action that needed to be taken and who to contact. One member of staff we spoke with said they now had confidence things would be "Dealt with appropriately" and necessary actions would be undertaken to deal with the situation. The training records and staff meeting minutes confirmed that staff had received updated training in this area and that how to make safeguarding referrals had been discussed at a recent staff meeting. Staff supervision records showed that safeguarding and whistleblowing procedures were discussed with staff on an individual basis.

Information had been added to the induction for agency staff working within the service to ensure they were aware of how to report safeguarding concerns. An agency worker told us "I had an induction the first day I came to work here. It was very good and I was told about the systems to follow which included reporting any concerns". There had not been any new safeguarding alerts raised since our last inspection.

At the comprehensive inspection on the 18, 19 and 23 May 2016 we found care plans, whilst identifying risks, did not always contain detailed information for staff on how to minimise the risks and in some cases contained conflicting information.

People did not always receive care as planned when needing assistance with safe moving and transferring. People were sometimes cared for by staff who were unfamiliar with their needs due to being agency and bank workers.

Although people were provided with call bells, not all were able to use them due to cognitive impairment. There were no formal observation charts in place and staff did not sign to confirm they had checked the person was safe and well every hour.

Where people occasionally displayed behaviour that others may find distressing, care plans contained some guidance for staff but there was not enough detail to inform them how to prevent or minimise the risk.

Accidents and incidents were not always recorded appropriately and reported to the management team.

It was not always clear if people had been supported to have sufficient to eat and drink. The systems in place for monitoring people's food and fluid intake were not robust and indicated that people's intake was not being sufficiently monitored. There was a risk that people were not always being assessed for specialist dietary needs.

These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we issued a warning notice to the provider. At this inspection we found the provider had made the necessary improvements to meet the shortfalls in relation to the requirements of Regulation 12 as described above.

During our last inspection we found that whilst risks assessments had been completed the care plans did not always contain detailed information for staff on how to minimise the risks. At this inspection the nurse in charge explained that all risks assessments had been reviewed and updated to contain guidance for staff on how to minimise the risk of harm to people. Risk assessments we reviewed contained information on how staff should support people to reduce the risk of harm occurring. For example one person's care plan contained information stating the person required the assistance of two staff when transferring from their bed to their wheelchair or armchair. It detailed the type of hoist and sling that was to be specifically used to support this person when transferring. Clear guidance was in place to support people who were at risk of pressure ulceration. Risk assessments were in place which guided staff on how frequently the person required repositioning to reduce the risk of pressure ulceration occurring. This information was also held in the person's folder in their room and was available to agency staff for quick reference.

People were cared for by agency staff who may be unfamiliar with their needs. The nurse in charge explained that all agency staff now undertook a comprehensive induction. There was an induction checklist which was gone through with each agency worker during their first shift. The checklist was signed by a member of staff to evidence the information that had been gone through during the induction. The nursing home tried to use the same agency staff to ensure people received consistent care. Each person had an accessible care plan in their room which contained an overview of their needs, the care they required and how they wished to receive this care. This meant where agency staff did not have the time to read the person's full care plan they had access to information relating to the daily care and support the person needed them to provide. Agency staff spoke positively about this information stating "The information is very helpful and acts as a quick reference of the care people need".

Agency staff confirmed they had received a comprehensive induction during their first working shift at Fountain Place. One agency worker told us "As well as the induction I received a very good handover of information about each person which was on a written sheet. X (nurse in charge) checked I had read the information folders. The information was very good and if I needed to know anything more then I could ask X". They also said "During my induction I was shown where equipment was kept, how call bells worked, fire procedures and systems or reporting in place". Another agency worker told us "The information that is available is good. The handover was informative and told me what care people needed". One of the agency workers commented that they wished "More homes would do this kind of induction".

A visiting relative said "There is continuity of care now as they are using consistent agency staff. Everyone is working extremely hard and the management are communicating with me monthly about what is happening. I am satisfied X (family member) is getting good care".

At our last inspection we found accidents and incidents were not always recorded appropriately and reported to the management team. As a result of this the provider had implemented a new accident/incident reporting form which was reviewed by the interim manager each month to ensure appropriate actions had been undertaken. The reporting form had been amended to include details of the accident/incident, any observations in place up to 24 hours after the accident/incident, body maps and any investigations undertaken. Guidance for staff stated that they must complete the form and inform the interim manager who would then review the situation. This meant it was much easier to track when the incident had been reported and what actions, if any, had been taken. The nurse in charge told us the interim manager audited the forms to identify any trends or patterns occurring. There had not been any accidents or incidents reported since our last inspection. Staff and agency staff we spoke with confirmed they were aware of the reporting procedure.

People's care plans had been reviewed to ensure they contained information for staff on how to prevent or minimise people's risk of distress and how to keep themselves and the people using the service safe. One person's care plan we reviewed now contained detailed guidance of how staff should support this person if they were refusing to have their personal care needs met. The guidance advised staff to explain to the person what was happening and what support they wished to offer. If the person became anxious the care plan advised staff to leave the person for five to ten minutes and then try again. The guidance also stated that it may be appropriate for a different member of staff to support the person. Information on how to support people's emotional well-being was also included in the quick reference guidance available to both staff and agency workers.

At the last inspection it was not always clear if people had been supported to have sufficient to eat and drink throughout the day. The systems in place contained conflicting information regarding people's nutritional needs and monitoring forms were not always completed. During this inspection we saw charts for monitoring people's nutritional and fluid intake were available in people's rooms so staff were able to complete them as soon as the person had been supported to have food or fluid. Agency staff had been made aware of the need to complete these monitoring forms. Records we reviewed had been completed and nutritional advice on these forms corresponded with the information in people's nutritional care plans. Guidance in people's care plans contained information on their nutritional requirements. For example how much thickener people required in their drinks and what type of diet they required such as pureed or soft. This information was available to agency workers.

At the last inspection we observed that although people were provided with call bells, not all were able to use them due to cognitive impairment. In two care plans we looked at, the inability to use the call bell had been documented and staff directed to check the person every hour. However there were no formal observation charts in place and staff did not sign to confirm they had checked the person was safe and well every hour. During this inspection we saw hourly monitoring checks were in place and completed for those people who required it. Agency staff confirmed they were aware of these checks and the need to complete the forms to evidence the checks had taken place.