Fountain Nursing and Care Home Limited

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Inspection report

11-17 Fountain Road
Edgbaston
Birmingham
West Midlands
B17 8NJ

Tel: 01214296559

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 March 2017. After that inspection we received concerns in relation to how people were kept safe from the risks associated with their specific condition. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fountain Nursing and Care Home on our website at www.cqc.org.uk

This focused inspection took place on 6 July 2017 and was unannounced. The inspection team consisted of one inspector. Fountain Nursing and Care Home Limited is a care home with nursing for up to 27 people, some of whom are living with dementia. At the time of our inspection 27 people were using the service.

At the time of the visit the service had a registered manager who was present during 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that the provider had not taken appropriate action to protect people from avoidable risks and plans to respond to emergencies were not robust. Several items of equipment designed to protect people from harm were broken or not working properly. Rubbish and equipment stored in the garden presented a trip hazard. The provider conducted regular checks of fire detection systems and equipment but evacuation and fire training for staff was not robust.

People received their medicines from nursing staff that were trained to do so. The registered manager had recently taken action to improve the safe storage and recording of medicine. However, we found that the management of some medicines meant that people could not be assured they would receive medication which remained effective.

People we spoke with told us that they felt safe at the home. Staff we spoke with demonstrated that they were aware of the action to take should they suspect that someone was being abused. On several occasions we saw that staff did not support people in a dignified and respectful manner.

The provider did not have robust systems in place to assess the quality of the service and drive a culture of sustained improvement. The provider did not always have regard to concerns raised by other agencies in order to improve the service or demonstrate a learning culture. Quality audits had failed to identify several faults with equipment and the environment. Care plans were not audited on a daily basis as planned.

There were enough staff, suitably deployed, to support people promptly. The registered manager conducted suitable recruitment checks to ensure people were supported by suitable staff.

The registered manager demonstrated knowledge of the type of events they were required to notify us of and their latest inspection ratings were displayed appropriately. People who used the service and staff told us they were pleased with how the service was led.

You can see what action we have asked the provider to take at the back of the full version of the report.

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 always safe.

Several items of equipment designed to protect people from harm were worn or not working properly.

People could not be assured they would receive medication which remained effective.

Staff were aware of the action to take should they suspect that someone was being abused.

There were enough staff, suitably deployed, to support people promptly.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People could not be assured staff would respect their dignity.

People were supported by a consistent group of staff with whom they had built up close and positive relationships with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager had failed to ensure that standards were maintained and improved upon.

Quality audits had failed to identify issues with equipment and the environment that needed to be addressed.

People who used the service said they were pleased with how the service was led.

Fountain Nursing and 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.

We undertook an unannounced focused inspection of Fountain Nursing and Care Home on 6 July 2017. The inspection was undertaken by one inspector. This inspection was done in response to concerns we received after our 30 March 2017 inspection had been made. We planned to inspect the service against two of the five questions we ask about services: is the service safe and, is the service well-led? However during our visit we identified concerns which made it necessary to inspect against an additional question we ask about the service: is the service caring?

As part of planning the inspection we reviewed any information we held about the service. We checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We reviewed information we received from an agency who commissions some packages of care from the service and a health professional who supports people at the home. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit we spoke with four people who lived in the home. Some people living at the home were unable to speak with us due to their health conditions. We used our Short Observational Framework for Inspection (SOFI) and spent time in communal areas observing how care was delivered. Using this tool helped us to understand the experience of people who could not talk with us.

We also spoke the registered manager, two nurses and five care assistants. We spoke with a person who was visiting a friend at the home and a health care professional who was also visiting a person who used the

service. We sampled the records including three people's care plans, staff recruitment files, medication and quality monitoring.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received information from another agency that practices in relation to managing the risks associated with people's specific conditions, their medicines and the environment were not robust. These included not keeping peoples' care records up to date when they required support with PEG feeding or turning; poor recording of samples; staff were unsure how to support people who were at risk of choking: some mechanical beds did not work properly and checks were not undertaken to ensure people's bathwater water would be at a safe temperature. Processes in place did not ensure people's routine screening tests were well managed or that people who were at risk of skin sores would be managed appropriately. Records did not demonstrate that medicines had been administered safely or as prescribed. People's creams were not managed safely.

At our last inspection in March 2017 we reported that the service was safe however we found that the provider had failed to maintain this standard. Although the provider was taking action in response to the concerns raise by the other agency we found that people were at risk of receiving unsafe care.

Although all of the people we spoke with told us that they felt safe at the home we found that further improvement was required to protect people from harm. We found that some bed rails and their covers were broken and worn. This put people at risk of being injured and the worn covers could not be properly cleaned which failed to protect people from the risk of infection. A restrictor to prevent people from falling out of a first floor window was not effective at stopping the window from opening further than was recorded by the provider as safe. We found an air mattress could not be adjusted to the necessary setting to help reduce the risk of a person developing pressure sores. Although a member of staff was aware of this fault it had not been brought to the attention of the registered manager and no action had been taken to rectify it.

We found broken furniture, ladders and decorator's equipment stored on the patio area immediately outside the back of the home. Although most people who used the service required support from staff when using this area there was a risk these items could have presented a trip hazard and upholstered items had become sodden whilst exposed to the elements, this compromised the value to people of enjoying being outside when the weather was warm and sunny. The registered manager told us they were waiting for the provider to authorise the supply of a skip so these items could be removed. They had not taken effective action to ensure these items were removed promptly or stored safely until they were disposed of.

The provider conducted regular checks of fire detection systems and equipment. Staff received training in how to support people in the event of a fire however this training was not robust. We reviewed the fire training staff received at induction and the registered manager agreed that this required updating to reflect the latest staffing structure. This lack of clarity mean that people could not be assured that staff would have the knowledge they required to evacuate them in the event of a fire.

People who required support to receive their medicines safely said they were happy with how they were supported. One person told us, "I trust them [Staff]. A nurse comes and checks they [medicines] are okay." At our last inspection we found that medicines were managed safely, however this standard had not been

maintained. Although the registered manager had taken action to improve how medicines were stored and recorded we found that systems to record the opening and 'use by' dates of some medication required further improvement. Several medicines did not have a record of when they need to be used by. People could not be assured they would receive medication which remained effective. Staff had been using different systems concurrently to record the administration of controlled drugs which had put people at risk of receiving incorrect amounts. Medicines were administered by nursing staff who were trained to do so. They told us they received regular medication refresher training and they appeared knowledgeable and confident when administrating medicines.

The registered manager had reviewed each person's care records to identify any gaps in information about how the person required supporting. This included reviewing how people required support with PEG feeding. Although omissions had been identified the plan to update records had not been adhered to. Not all records contained up to date information for staff about how staff were to safely meet people's latest care needs.

The issues related to areas of the home, safety equipment, medication management and up to date fire evacuation guidance was a failure to provide safe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with demonstrated that they were aware of the action to take should they suspect that someone was being abused. One member of staff told us, "I will tell the nurse, manager and we can call the police or CQC." Another member of staff told us, "We have to protect people from physical, emotional and financial abuse." The manager and staff told us that all members of staff received training in recognising the possible signs of abuse and how to report any suspicions. We saw that further safeguarding training was being planned.

People who used the service told us there were enough staff to meet their needs. One person told us, "They are very attentive. I don't have to wait." We observed that staff were suitably deployed around the lounges and communal areas so they could support people promptly. Staff we spoke with agreed there were enough staff employed to enable them to spend the required time with people. We reviewed the files of two members of staff and saw that staff had undergone interviews and checks had been carried out before staff started work. These included Disclosure and Barring Service (DBS) checks to identify if applicants had criminal convictions and obtaining suitable references. This helped to ensure people were supported by suitable staff.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people told us that staff were caring and they enjoyed living at the home. People were supported by a consistent group of staff with whom they had built up close and positive relationships with. People felt they were involved in the home and the registered manager sought their opinions. At this inspection we found that this was still the case. One person told us, "Staff are very kind;" and a visitor said, "The staff are very good. They always look after [person's name] well." However at this visit we saw that staff practices did not always respect people's privacy and dignity.

Whilst in the rear garden of the home we saw that one person was being supported with personal care in their bedroom and staff had failed to close curtains before providing the support. This person was seen in a state of undress from outside the home. We brought this to the attention of the registered manager who prompted the member of staff to close the person's bedroom curtains. On another occasion a member of staff was using a hair dryer to dry a person's hair in a corridor while other people and visitors were walking past. This was not dignified or discreet. The member of staff told us this was normal practice and a visiting hairdresser would also use this area to cut people's hair. A nurse told us they needing to improve this practice. This practice did not support people to receive personal care in a private, dignified and respectful manner. The registered manager told us they were aware of this practice but they had not addressed this or identified a more dignified way of supporting people with this aspect of their care and support needs.

The registered manager told us that a recent audit by another agency had identified that screens for use by people who shared a bedroom could not be closed sufficiently to ensure their privacy. They advised that they had subsequently approached the provider for new screens. The registered manager's own checks and staff had not identified that action was required to improve the people's privacy.

Requires Improvement

Is the service well-led?

Our findings

Prior to our inspection we received information of concern in relation to aspects of how the service was run. This included a lack of care plan reviews, records did not contain people's end of life wishes, medication and equipment checks were not robust.

At our last inspection in March 2017 we reported that the service was well-led, however at this inspection we found that the registered manager had failed to maintain this standard. At this inspection we found that the systems in place to assess the quality of the service and drive a culture of sustained improvement had not been effectively used.

The provider did not always have regard to concerns raised by other agencies in order to improve the service. The provider had recently received advice from two other agencies to record the 'open' and 'use by dates' of medicines, however we found staff were still failing to do this. Although audits had regularly identified that a fridge which was used to store medication was not operating within an acceptable temperature range the registered manager did not taken action to rectify this until it was brought to their attention by another agency. Despite being made aware of the importance of maintaining suitable fridge temperatures the registered manager had failed to introduce checks to ensure other fridges kept in people's bedrooms were also operating within a safe temperature range. This lack of action failed to ensure that medication was being managed safely.

At our last inspection we reported that the provider's systems to monitor the quality of the service were robust however we found this had not been maintained. Recent audits had failed to identify when people were at risk of harm. Although audits of bed rails, window restrictors and pressure mattresses had been conducted regularly they had failed to identify or report several faults which were identified during inspections by other agencies and CQC. The registered manager had not reviewed these audits for their accuracy. The registered manager had reviewed medication administration records and current polices but had failed to identify erroneous or missing information identified through the inspection and by another agency.

In response to recent concerns from another agency about the quality of people's care plans the registered manager had introduced a programme to audit a sample of care records each day. This was to ensure they were up to date and records would contain details of people's end of life wishes. The registered manager told us however that records had not been reviewed as planned for three days prior to our visit due to staff absence. There was no contingency arrangements in place to ensure these records would be reviewed as planned. A nurse we spoke with who was responsible for conducting some of these reviews was unsure if the time scale to review all the records was achievable. They told us, "I will try my best." We were not assured that systems in place would ensure people's care records would reflect their latest care needs and preferences.

The systems in place to review aspects of the service and drive up improvement had not been used effectively and had failed to identify issues noted by other agencies and through the inspection. This was a

breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager demonstrated knowledge of the type of events they were required to notify us of and their latest inspection ratings were displayed appropriately. However failure to have regard to our previous reports and not maintaining standards in line with current registration meant they could not demonstrate a robust duty of candour.

All the people who used the service told us they were pleased with how the service was led. One person told us, "It's nice here." Another person said, "They do a good job." Staff told us that the manager and team leader were supportive and led the staff team well. Several members of staff we spoke with had worked at the service for several years. They told us this was because of the quality of the leadership. We spoke with a representative of a clinical commissioning group (CCG) who commissions packages of care from the service and two healthcare professionals who support people at the service. One person said the home supported people well and others said that they felt the service required improving. They said that although they had seen some improvements further evidence was required in order to demonstrate that these improvements would be sustained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that the equipment used for providing care or treatment to a service user was safe for such use. Regulation 12(2)(e). The provider did not ensure that medicines were safely dispensed in line with current legislation and guidance. Regulation 12(2)(g). The provider did not effectively assess the risk of, and preventing, detecting and controlling the spread of infections. Regulation 12(2)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems used to assess, monitor and improve the quality and safety of the services provided and to assess and manage risk was not effective and failed to ensure compliance with the regulations was established. Regulation 17(2)(a)