The Fountains Care Home Ltd

The Fountains Nursing Home

Inspection report

Victoria Park
Swinton Hall Road
Salford
Greater Manchester
M27 4DZ
Tel: 0161 794 5814
Website: www.example.com

Date of inspection visit: 12 October 2015
Date of publication: 14/03/2016

Ratings

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

Overall summary

This unannounced inspection took place on 12 October 2015. We last inspected The Fountains Nursing Home in December 2014 and was given the rating of 'Requires Improvement' overall and in four of the five key lines of enquiry. These included Safe, Effective, Responsive and Well-led. We also identified a breach of regulation with regards to Infection Control.

The Fountains Nursing Home is in Swinton, Salford and is owned by Liberty Healthcare. It provides residential and nursing care, as well as care for people living with Dementia. The home provides single occupancy rooms with en-suite facilities and is registered with the Care Quality Commission (CQC) to provide care for up to 98 people.

There are four units at the home, known internally as Parkview (Residential Dementia), Garden Rooms (General Residential), Victoria Suite (General Nursing) and The Lowry (Dementia Nursing). At the time of the inspection there were 88 people living at the home, across the four units.

Summary of findings

During this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing (two parts), Safe Care and Treatment (two parts) and Good Governance (two parts).

At the time of our inspection, the home manager was not yet registered with CQC and had been newly appointed in September 2015. 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.

We checked the home to ensure it was clean and if improvements had been made since our previous inspection. At the last inspection we saw that carpets and chairs were dirty and in needed to be replaced. This was mainly in relation to the Victoria Unit of the home. During this inspection we saw that they had been replaced. We did however see that some walls needed to be cleaned and dust removing from some skirting boards. We also saw that toilets were equipped with necessary hand washing guidance, soap and paper towels. This reduced the spread of infection.

The staff told us they did not think there were sufficient numbers of staff on shift to meet people's needs in a timely way. We found that two people who had been identified as being at high risk of falls, were not regularly observed by staff to ensure they were safe and were left unsupervised in quiet lounge areas on their own. Staff said they were unable to monitor these people because of the current staffing levels at the home. Additionally, there were only three members of staff working on the Park View unit, where three people needed full assistance to eat their meals. Another person needed to be observed when eating which we observed was not happening due to staff being focussed on these three people. One of the three members of staff also had a medication round to complete during this period.

We looked at how the home ensured people received their medication safely. We found inconsistencies with daily recordings of the medicines fridge temperature on the Park View Unit. Additionally, there were no clear protocols in place to guide staff on when PRN (when required) medicines should be given. The morning medication rounds on both Victoria Suite and The Lowry did not conclude until approximately 12pm. This would affect the timings of when people needed to receive their medication at other times of the day.

We undertook a tour of the building to ensure that it was safe for the people who lived there. On the Lowry, Victoria and Park View units, we saw that sluice room doors were unlocked which contained various cleaning products which could pose harm to people. Due to some people being wondersome around the units, they could easily access these areas and come into contact with these products unsafely. The medication treatment room on the Victoria Unit was also unlocked when we arrived at the home at 7am. This could place people at risk.

People living at The Fountains told us they felt safe. We looked at recruitment records and saw that checks had been carried out to help ensure staff were of suitable character to work with vulnerable people. This included undertaking DBS checks and seeking two written references from previous employers.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service had made DoLS applications as required. Several of the staff we spoke with felt that more in-depth training in this area would be beneficial to them.

Staff supervision was not always consistent at the home. Some of the staff we spoke with said they had not received supervision for some time.

The staff we spoke with said they had enough training available to them. We looked at the training matrix which showed staff were trained in subjects such as Safeguarding, Moving and Handling, COSHH, Fire Safety and Infection Control.

Two of the units at the home (The Lowry and Park View) cared for people living with Dementia and we checked to see what adaptations had been made to make these units more 'dementia friendly' for people. We saw hand rails, bedroom doors and toilet seats were painted in bright colours which would make them stand out more to people and be easier to locate. However, there were no

Summary of findings

memory boxes or things that people could touch and relate to as they walked around the unit. People's names were also written in small writing on their bedroom door and not all rooms contained a picture on the door to indicate whose room it was.

People told us they had enough to eat and drink. We saw information was available to help ensure any special dietary requirements were catered for. There was evidence in people's care plans that referrals were made and advice sought from other health professionals as required. We observed however, that the meal time experience was not always a pleasurable experience for people.

We observed staff interacting with people in a positive, respectful and friendly manner. People told us the staff were kind and caring. Staff were able to describe how they would support people to retain independence. People felt treated with respect by staff, however we saw that not all toilets in the Park View Unit contained locks, which would give people more privacy.

Some of the people who lived at the home and also visiting relatives told us that there was no continuity of care at the home. This was due to agency staff being used on a daily basis. One relative commented how they never knew who would be caring for their family member when they visited the home.

We looked at the records in place to demonstrate that people received a regular bath or shower at the home. On the Lowry unit for instance, many people were doubly incontinent and the records suggested they were only receiving one shower a week. Staff said that people often refused, however there was no evidence of what further action was being taken around this.

We looked at what activities were available to people living at the home. There was an activities co-ordinator who was only working across two of the units during the inspection. We were told a second post for this role was currently being recruited to. This meant that during the inspection, people on two of the units had nothing to do. Staff on these units said they didn't have time to do activities, due to being engaged in other aspects of people's care.

We saw no evidence within people's care plans of involvement from people living at the home. Several people living in Garden Rooms (General Residential Unit) had been assessed as having capacity to make their own decisions and could potentially have been involved in this process. There were also inconsistencies with recordings about people's likes, dislikes and personal preferences.

We looked at the most recent survey which had been sent out in 2014. We saw this asked people for their opinion about the food, their care, the environment and management. We saw no evidence of how negative comments were responded to, as no overall analysis had been completed once the surveys were returned, to demonstrate what action had been taken. This had been raised at our last inspection.

We looked at what audits were undertaken within the home, to ensure good governance. The only audits we were shown covered care plans and medication, however these had only been completed for the Park View and Garden Rooms Units. We saw no evidence of these checks being undertaken in The Lowry and Victoria Suites apart from one audit on Victoria in January 2015. This meant that any discrepancies would not be identified in a timely manner.

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?

Requires improvement

Not all aspects of the service were safe. Staff told us they thought there were not enough staff available to meet people's needs. We also observed that two people at high risk of falling were not supervised by staff. There were also not enough staff to properly support people at meal times.

Medication was not handled safely. Two of the four morning medication rounds did not conclude until approximately 12pm. There were also no clear PRN protocols in place for staff to refer to as to when they should be given. There were also inconsistencies with regards to temperature checks of the medicines fridge.

The premises were not always safe. This was because we found sluice room doors (Park View, Lowry and Victoria) unlocked and one of the medication treatment room doors (Victoria) unlocked when we arrived at the home.

Is the service effective?

Requires improvement

Not all aspects of the service were effective. Improvements were required to the environment to make it more dementia friendly. This included things such as memory boxes and objects people could touch and relate to as they walked around the unit.

Staff supervision was not consistent. Some of the staff we spoke with said they felt that supervisions were not regular enough. The records we looked at also confirmed that supervision did not always take place on a regular basis.

The meal time period was not a pleasurable experience for people. We saw there was a lack of cutlery provided to people and staff did not always explain to people what food they were eating on the day. One person asked for an alternative meal and was told by staff it wasn't possible because they had already made their choice earlier.

Is the service caring?

Requires improvement

Not all aspects of the service were caring. People said that staff were caring and we saw people being treated with dignity and respect. We did however, see that some toilet doors did not have a lock, particularly on the Park View Unit. This would give people more privacy.

Some people who lived at the home told us 'continuity of care' was a problem within the home, due to so many agency staff being used. This meant people could not always get to know the staff who would be caring for them.

Some people at the home were doubly incontinent and we saw they were only offered one shower a week. Where they had refused, staff had not taken any action about this or sought further advice.

Summary of findings

Is the service responsive?

Not all aspects of the service were responsive. We found no action had been taken where areas for improvement had been suggested during the most recent survey.

People living at the home said there was not always enough for them to do. At the time of the inspection, activities were only taking place on two of the units.

We did not see any evidence that people who lived at the home were involved in the reviews of their care plans or had been able to contribute towards the content. Additionally, information about people's likes, dislikes and personal preferences was not always recorded.

Requires improvement

Is the service well-led?

Not all aspects of the service were well-led. This was because regular audits of care plans and medication were not undertaken on the Victoria and Lowry Units.

Staff said that team meetings were not always regular. We only saw evidence of one team meeting taking place on some of the units which was in April 2014.

There was a manager in post, although they had only started in September 2015 and as such, were not yet registered with CQC.

Requires improvement

The Fountains 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 12 October 2015 and was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission and two specialist advisors. The specialist advisors were a Registered Nurse and a GP (General Practitioner). We also used an expert by experience. An expert by experience is a person who has experience of using or caring for people in this type of service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports, details of any notifications that the service had sent us about safeguarding, or other important events and any feedback that had been sent to us about the service. We also contacted Salford Council and asked for their feedback about the service. This included Safeguarding, Infection Control, Funded Nursing Team and Environmental Health. We did not receive a response to our request from all these agencies prior to our inspection.

During the inspection we spoke with nine people living at the home. We also spoke with 10 relatives who were visiting at the time of our inspection and 16 members of staff. These included night staff, day staff, nurses, the cook and the newly appointed home manager.

We looked at documents relating to people's care including care plans and staff recruitment records. We also looked at other documents related to the running of the care home including policies and procedures, medication records and quality assurance audits.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe, as did their relatives. One person said; "I'm completely satisfied here. It took me a while to settle in but I enjoy it here. I don't think they could do anything better. If you're settled you don't think about it. I feel safe here. I know all the staff. I wouldn't let anyone harm me." Another person told us; "I feel safe here, I really do. The staff are what makes it worthwhile coming here. They are really nice." A relative also told us; "She likes the staff here and it has calmed her. She says that she won't go into hospital because she feels safe here. She's never complained about the staff here." Another relative added; "She was originally upstairs but she didn't settle there. So they moved down here. There are no problems down here. She' a lot happier and safe down here."

As part of the inspection we checked to see if there were sufficient staff working at the home, in order to meet people's needs safely. During the day, Victoria Suite was staffed by a nurse and five care assistants. The Lowry was staffed by a nurse and four care assistants. Park View was staffed by a senior carer and two care assistants. Garden Rooms was staffed by a senior carer and two care assistants. At the time of our inspection, we were told the home did not use a dependency tool to determine how many staff were required, to safely meet the needs of people living at the home.

During the inspection we found that these staffing levels were not sufficient to safely meet the needs of people living at the home.. On the Lowry Unit, at 7.30am we observed one person who had been identified as being at 'high risk' of falls. This person had recently been referred to the falls service. Several of the incidents in relation to this person had also been raised as Safeguarding Concerns. Their care records, which had been completed during the night (11 and 12 October 2015), stated that they had fallen twice and had had one 'near miss'. It also stated that this person 'definitely required one to one care', due to being high risk of falls. Their care plan also stated that staff needed to be 'vigilant' and to keep an eye on this person. At 7.45 am, we saw this person was left unattended for approximately 25 minutes, with no member of staff coming into the lounge area to check this person was safe. This person looked very unsteady on their feet and proceeded to urinate on the wall and an electric fan. They then tried to plug the fan into the wall. When we raised our concerns with staff we were told; "This is what I mean. We can't keep an eye on (the person) with the way the staffing levels are. Other people on this unit need seeing to as well".

This person's care plan also indicated that they could often be aggressive towards other people who lived at the home. During this period that we saw this person unsupervised, there were also two other people sleeping in their chairs who had chosen to sleep there during the night. We saw that two verbal altercations took place in this time, where people were getting agitated with each other and we were concerned that if this situation had escalated, staff would have been unable to respond and intervene in a timely manner, due to no staff being present in the room.

We also observed another person who lived on the Park View Unit who had also been identified as being at 'high risk of falls.' Their care plan stated they needed to be observed by staff as they would often attempt to walk without support and were at risk of falling. This person had fallen four times over the months of August and September. At approximately 11am, we saw that this person was sat unsupervised in the lounge area on their own and was attempting to get of their chair to walk. We raised our concerns with staff who said that due to current staffing levels on the unit, they were unable to supervise this person regularly to ensure they were safe. One member of staff said; "We can't do it with the way things are. We need more staff here".

We found there were not enough staff available to support people at meal times on the Park View Unit. On this unit, there were three members of staff, including the senior carer who was undertaking a medication round. Another member of staff was required to serve the food from the dinner trolley. Three people on this unit required full assistance to eat their food and one person also needed to be observed whilst eating, to ensure their safety. During this period, we saw the senior carer had to stop the medication round to provide assistance to the other two members of staff. As the focus from staff was on the people who required assistance to eat, we saw staff did not observe the person needing to be watched when consuming their food. This could have placed this person at risk. One member of staff said; "This is like organised chaos. Wait until tea time. It gets worse then".

Requires improvement

Is the service safe?

These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We checked to see if medication was handled safely within the home. At the time of the inspection, the home used the Bio-Dose system. The morning medication rounds on both Victoria Suite and The Lowry did not conclude until approximately 12pm. This would affect the timings of when people needed to receive their medication at other times of the day. We saw medication was administered by either nurses or senior care staff within the home. When we checked the training matrix, we saw that they had received appropriate training. We also found that controlled drugs were stored in a secure cabinet with staff providing two signatures once the medication had been given. People's medication was stored in secure trolleys which we saw were not left unattended when not being used. Medicines were stored in a fridge to ensure they were kept at a certain temperature. However we found inconsistencies with daily recordings of the medicines fridge temperature on the Park View Unit. These missed recordings had occurred between 6 August and 6 October. If the temperatures of the fridge are not checked regularly to ensure they are within the correct range, medicines may not work properly.

We also found there were no clear protocols in place to guide staff on when PRN (when required) medicines should be given. The home employed agency staff on a regular basis, who may not always be familiar with what peoples medication requirements were, due to not working at the home on a consistent basis. This meant that if the guidance is not there for them to refer to, they may not know when to give the medication and under what circumstances. There were also a number of people living at the home who could not verbally communicate. This meant staff could be unaware if people were in pain, due to them being unable to communicate effectively.

These issues meant there had been a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We undertook a tour of the building to ensure that it was safe for the people who lived there. On the Victoria, Lowry and Park View units, we saw that sluice room doors were unlocked which contained various cleaning products that could pose harm to people. Due to some people being wondersome around the units, they could easily access these areas and place themselves at risk if they were to come into contact with these products. The people we did see wandering on the corridors were often unsupervised and if they had entered these areas, staff would have been unaware. Additionally, on the Victoria Unit, we found the medication treatment room door was unlocked. This meant that if people had entered the room, they could have placed themselves at risk. We asked the manager if any daily checks or 'walk arounds' were undertaken on the units, to ensure that the premises were safe, however we were told that none were undertaken.

These issues meant there had been a breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

At our previous inspection we had concerns with regards to infection control and found certain areas to be unclean. This was mainly with regards to the Victoria Unit. We saw that carpets and arm chairs were badly stained and needed to be replaced as this could increase the risk of infection to people living at the home. We saw that arm chairs and carpets had since been replaced. We did however observe that some skirting boards needed to be cleaned where dust had built up and some walls wiping down which had stains on them. We also checked toilet and bathroom areas and found that they were equipped with appropriate hand washing guidance, paper towels and a foot operated bin which enabled waste to be disposed of safely therefore reducing the risk of infection.

We checked to see that staff who worked at the home, had been recruited safely. During the inspection we looked at a sample of seven staff recruitment records and saw that application forms had been completed, interviews had been carried out and DBS (Disclosure Barring Service) checks had been undertaken. The files we looked at also contained evidence that references had been sought from previous employers before staff began working with vulnerable adults.

The staff we spoke with were aware of potential indicators of abuse or neglect, and were aware of how to report any concerns appropriately. One member of staff said to us; "I would look for bruising and document everything straight away". Another member of staff said; "Bruising is always an obvious one. I'd also notice a change in people's behaviour and see if they were acting differently around people". A

Requires improvement

Is the service safe?

third member of staff also told us; "I think I would check the body map to see if any bruising or marks were normal or out of the ordinary. If I was concerned about it though I would speak with my manager".

People's care plans contained risk assessments with detailed control measures about how to keep people safe. These covered areas such as mobility, nutrition, pressure sores and maintaining a safe environment. We saw that where people had been identified as being 'at risk', a clear description of the control measures in place had been provided. We also saw that several environmental risk assessments had been undertaken. These covered people leaving the building, fire, food poisoning, cross infection and staff injury due to aggressive behaviour.

Requires improvement

Is the service effective?

Our findings

Two of the units at the home (The Lowry and Park View) cared for people living with dementia and we checked to see what adaptations had been made to make these units more 'dementia friendly' for people. We saw hand rails, bedroom doors and toilet seats were painted in bright colours which would make them stand out more to people and be easier to locate. However, several people's bedroom doors were painted the same colour, which could still prove confusing for people. There were also no memory boxes containing personal items, or things that people could touch and relate to as they walked around the unit. People's names were also written in small writing on their bedroom door and not all rooms contained a picture of whose bedroom it was. One person who had recently moved to the home had their name scribbled in pencil on their bedroom door, which was difficult to read. This could make it difficult for this person to find their bedroom successfully.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

Staff supervision was not always consistent at the home. Some of the staff we spoke with said they had not received supervision for some time, whilst others provided different responses about how often they took place. We checked supervision records and found they were not consistent for each member of staff. This meant that there were missed opportunities for staff to discuss their work, concerns or any training and development requirements they had in a confidential setting. One member of staff said; "I have had supervision this year, but I wouldn't say they take place regularly". Another member of staff said; "It has been a while since I had one. I couldn't say exactly when it was". The home manager told us they would try to ensure that staff supervision was conducted more regularly, now that they were in post at the home on a regular basis. Due to the inconsistencies with staff supervision, this meant there had bee a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We asked people who lived at the home and their relatives for their opinion of the food. One person said; "I like the food sometimes. Sometimes it's better than others." Another person told us; "The food can be good, but it can be mediocre. It is a balanced diet. You get what's put in front of you." A visiting relative also said; "Sometimes she doesn't like the food. They will find her something else although they are ready meals so they can't always find something else." Another relative told us; "They make sure she eats well. The meals are good."

We observed the lunch time period on each of the four units of the home during our inspection. On two of the units (Victoria and Garden Rooms), we saw that lunch time was not always a pleasurable experience for people. At the start of the meal there was no cutlery, napkins, salt, pepper and no side plates for people to use. On Garden Rooms, soup was given out to all 14 people in the room, however no explanation was provided as to what soup it was. One person asked, "What soup is it?" A member of staff replied "I'll show you.", however they didn't state what it was. Another person sat close by said, "What soup did they say it was?" Another person said "I don't know." We also observed one person asking for an alternative meal and said; "Can I have some sandwiches?" A member of staff replied "I don't think you're down for sandwiches today." This meant this person was unable to have a meal of their preferred choice. We raised this issue with the manager.

The choice of meal for the day was sauté potatoes and cheese, leek and egg pie. A dessert of strawberry mousse was also available for people. In Park View, there was no menu displayed to inform people of what the meal was. A member of care staff was also required to collect the food trolley from the kitchen which meant an additional staff member was taken from the unit during this period. Although the trolley had been brought into the dining room, it took approximately 20 minutes to serve the food. Two people got up and walked off due to their frustration of having to wait for the meal. Another person attempted to eat another person's meal due to having to wait. Three of the people on this unit also required a 'pureed' meal and although this was provided for them, we saw it was left on the side for 15 minutes before being served due to staff assisting other people. This food would potentially have gone cold and not been pleasant to eat. We raised our concerns about the meal time experience to the manager.

There was an induction programme in place which staff were expected to undertake when they first began working at the home. This enabled staff to gain an understanding of the expectations to undertake the role, to meet the people they would be caring for and to familiarise themselves with

Requires improvement

Is the service effective?

policies and procedures. Each member of staff we spoke with told us they undertook the induction when they first began working at the home. One member of staff said; "I was able to do three or four days of shadowing when I first started working at the home. I also covered fire, coshh, safeguarding and infection control". Another member of staff said; "Personally, I felt I learned quite a lot during the induction, it was good".

We looked at what training staff had available to them in order to support them in their role. We looked at the training matrix which showed staff had received training in core areas such as moving and handling, safeguarding, coshh, fire safety, infection control, medication and dementia awareness. The staff we spoke with told us that on the whole, they were satisfied with the training available to them, although they felt that more in depth training around DoLS, Challenging Behaviour and Dementia Awareness would be beneficial to them, in an environment like the Fountains.

The staff we spoke with were able to provide examples of how they sought consent from people who lived at the home. One member of staff said; "I would ask if they would like help initially because if somebody didn't want me to do something then I wouldn't do it. It's important to communicate". Another member of staff said; "I would explain what I was doing and check that it was what they wanted. Sometimes people might push you away and I would take that as them saying they don't want any help. If somebody didn't have capacity to tell me then I would try and read their body language".

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service had made DoLS applications as required. Several of the staff we spoke with felt that more in-depth training in this area would be beneficial to them.

We saw that people had access to relevant health professionals as required and any involvement around this was recorded in their care plans. This included the falls service, district nurses, opticians, physios, chiropodists and general practitioners.

Requires improvement

Is the service caring?

Our findings

People who lived at the home and their family members said the staff were kind and provided them with support and were caring. One relative spoke told us about the good care her mother had received, stating that her life had been extended by 18 months as a result.

During the inspection we received positive comments from people who lived at the home and their relatives about the care they received. One person said; “The place is very good. The carers are very good”. Another person said; “I don’t mind living here. Nothing compares to home but this is the best place for me. The staff are nice to me and they treat me well”. Another person said; “I can’t complain. Fortunately I can do bits for myself still but when I need the staff they are always there for me”. A fourth person added; “The care is good here I would say”.

We also spoke with visiting relatives and family member during the inspection. Comments from them included; "The two young girls who were on yesterday were very compassionate, caring and interactive. There are some cracking staff on Garden View”. Another relative added; "I think the staff are very kind. It's not an easy job." Another relative said to us; "They do really well with her. She's lived an extra 18 months because of the care in here”. A fourth family member said; "I think it's very good. They look after her well”.

Some of the people who lived at The Fountains and also visiting relatives told us that there was no continuity of care at the home. This was due to agency staff being used on a daily basis which we observed at the time of our inspection. One visiting relative commented; “You just simply don’t know who is going to be here from one day to the next when we visit”. Another relative said; “I can’t see how caring relationships can be developed when a member of staff from the agency is here one day and then gone the next. They need a lot more regular staff here”. A member of staff also told us that there were language barriers between staff and people due to agency staff coming from different ethnic backgrounds. This member of staff said; “I tell them what to do and they say they don’t understand what I mean most of the time”. Another member of staff added; “Agency staff don’t know people’s needs. We have to keep checking that things are done correctly”. We raised our concerns with the home manager who told us that staff recruitment was on going, but that the home was having great difficulties in recruiting full time nurses to work at the home.

We looked at the records in place to demonstrate that people received a regular bath or shower at the home. On the Lowry unit for instance, many people were doubly incontinent and the records suggested they were only receiving one shower or bath a week. Staff said that people often refused, however there was no evidence of what further action was being taken around this, such as speaking with family members or contacting the GP for further advice. One visiting relative said to us; “Mum only gets a bath once a week. She is wearing the same nightie from Saturday. We have now given her a proper wash because we weren’t prepared to wait”. Another relative said; "They overlook things. My mum only has a bath once a week. That is not satisfactory for someone who is doubly incontinent." We spoke with the manager about these concerns who said they would speak with staff to ensure they took appropriate action when people refused certain aspects of their personal care. Due to accurate records not being maintained, this meant there had been a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

On the Victoria Unit, there were high numbers of people being cared for in bed. Although, nobody had any pressure sores at the time of the inspection, there was the risk that these could develop, due to being in bed all day. There were air flow mattresses in place where necessary and staff displayed a good knowledge of pressure area management. We saw that within people’s bedrooms, there was a checklist of care tasks that had been carried out. These covered food/fluid intake, pressure care checks, creams applied and skin integrity. Where people were cared for in bed however, this was not always accurately recorded in their care plan that this was what they wanted to do. This meant it was difficult to establish if this was people's preferred choice of how they spent their day.

The staff we spoke with displayed a good understanding about how to treat people with privacy, dignity and respect. One member of staff said; “I always check which toilets people want to use as some people tend to have different choices. I wait outside as well which is what I would expect if it was me”. Another member of staff said;

Requires improvement

Is the service caring?

“When we go into somebody’s room to provide personal care we would always close the door behind us”. Another member of staff said; “If we are assisting anybody in their bedroom during the day we always close the curtains for privacy”. However we observed that not all toilet doors in the Park View Unit had locks on them, which would give people an increased sense of privacy when using these facilities. We raised this concern with the home manager.

Whilst speaking with staff we asked them about how they aimed to promote people’s independence whilst they lived at the home. One member of staff said; “If I was to try and promote somebody’s independence then I would give people the choice and let them have a go first”. Another member of staff said; “See what they can do for themselves first. For instance if they can take off their own pants or jumper then I will let them do that”. Another member of staff added; “I’ll often let people wash themselves in the shower first before offering any kind of assistance”.

Requires improvement

Is the service responsive?

Our findings

We saw several examples of where the home had been responsive to people's needs. For example, where one person had fallen several times at the home, they had been promptly referred to the falls service in order to seek further advice. Another person had been identified as having swallowing difficulties and they had been appropriately referred to the Speech and Language Therapy (SALT) team by staff. We also saw that these people received a 'pureed' meal at lunchtime. Additionally, at the time of our inspection, there was nobody living at the home who had pressure sores, although we saw that people were re-positioned at regular intervals and were sat on pressure relief cushions in order to prevent them from developing.

We asked both people who lived at the home and their relatives if they felt the care they received, was responsive to their needs. One relative said; "The staff turn him on a regular basis. They also wash him in bed and he needs two people to care for him which he always receives. The staff deal with him in a respectful, and dignified way. The staff are wonderful". Another relative said; "The care is fantastic. My mum is well looked after. The staff always keep me informed of things and the food is great". Another relative added; "They look after my dad as if he was their own father".

We saw that before people moved into the home, an initial assessment was undertaken to establish the types of care people required. This covered areas such as mobility, eating and drinking, continence, communication, sleeping and socialising. Staff at the home had also made an effort to establish information about people's past life events such as where they lived, any early memories, hobbies and interests and the school they attended. However, we found that this information was not consistent in each of the care plans we looked at, as this section had not always been completed by staff. We raised this concern with the manager, due to the fact that the home was currently using high numbers of agency staff who may be unaware of what peoples preferred choices were.

During the inspection we looked at a sample of care plans for people who lived at the home. The care plans provided guidance for staff about the kinds of care people required. People had care plans for areas such as pressure sores, nutrition, personal care, mobility and communication. We saw that care plans were reviewed each month or when required. Despite this we did not see evidence that people were involved in the reviews of their care plans or had been able to contribute towards them. Some of the people who lived at the home, particularly in Garden Rooms, had been deemed to have the capacity to make their own decisions and could have been involved in this process. We spoke with the manager about this concern, who said they did try to involve people, but that this was not always clearly recorded.

We looked at what activities were available to people living at the home. There was an activities co-ordinator who was only working across two of the units during the inspection. We were told a second post for this role was currently being recruited to. This meant that during the inspection, people on two of the units had nothing to do. Staff on these units said they didn't have time to do activities, due to being engaged in other aspects of people's care. In the mornings the activities coordinator played cards, dominoes and used memory books with people about past life events. One person was a Manchester United fan and the activities coordinator took a daily newspaper and read all the football news to them. Originally, there were two co-ordinators undertaking this task but one had left. We also saw the activities coordinator reading with people, whilst others had their nails painted.

There was a complaints procedure in place. The procedure was clearly displayed in the reception area of the home. We also looked at the complaints which had been made against the home. We saw that there were details regarding what the complaint had been about and what action had been taken. There was also a copy of the response which was sent to the complainant. In addition, there was a comments and suggestions box in the reception area of the home, where people who lived at the home, or visitors, could make comments in a confidential manner.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection, the home manager was not yet registered with CQC and was going through the application process. The manager had only started working at the home in September 2015. The previous home manager had left earlier in 2015. 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.

We saw that there was a designated leader on each unit. For instance, The Lowry and Victoria Units were overseen by a lead nurse, with Park View and Garden Rooms being over seen my a senior carer. Their duties were overseen by the general manager (Park View and Garden Rooms), with Victoria and the Lowry being overseen by a clinical lead, in the absence of a regular registered manager. One relative said to us; "They (the managers) don't seem to communicate with relatives. They had an open day to come and see the manager. It was at 2.00 pm on a Wednesday so we couldn't come as we were working." Another relative said; "The higher (management) structures need improving. You never see the senior managers around the home." A member of staff on the Lowry unit said; "There is no support up here at all. Nobody keeps an eye on what we do."

We looked at the most recent survey which had been sent out in 2014. We saw this asked people for their opinion about the food, their care, the environment and management. We saw no evidence of how negative comments were responded to, as no overall analysis had been completed once the surveys were returned, to demonstrate what action had been taken. This had been something which we raised as a concern at the previous inspection. For example, comments had been made about the pastry not being nice in some of the meals, that night time support needed to be addressed and that the staff working at the home were not regular, meaning they were unfamiliar to people. We spoke with the manager about this concern who acknowledged this and said that they would introduce an overall summary, in response to what people had said.

We looked at what audits were undertaken within the home, to ensure good governance. The only audits we were shown covered care plans and medication, however these had only been completed for the Park View and Garden Rooms Units. We saw no evidence of these checks being undertaken in The Lowry and Victoria Suites apart from one audit on Victoria in January 2015. These issues meant there had been a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance.

Some of the staff we spoke with said that team meetings were not regular enough. One member of staff said; "We have had them in the past but they are not as regular as they used to be. I don't recall the last one". Another member of staff said; "I've not been to one since I have worked here and I have been here since May this year. We looked at the minutes from the most recent team meetings. The last Garden Rooms meetings we saw evidence of was 15 April 2015, whilst the last meeting on Victoria Suite was 8 April 2015. A meeting had taken place for staff on The Lowry on 23 July 2015. This meant that staff may not always have regular opportunities to discuss concerns or suggest areas for improvement at the home, especially because regular staff supervision was also not taking place. We raised this concern with the manager.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included Falls, Infection Control, Medication, Complaints, Whistleblowing, Safeguarding and Moving and Handling. This meant that staff had access to relevant guidance if they needed to seek further help or advice about practice within the home.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Appropriate systems were not in place to ensure people received their medication safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Appropriate systems were not in place to ensure the premises were consistently safe for people living at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Appropriate systems were not in place to ensure the quality of service was monitored regularly to ensure good governance.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Appropriate systems were not in place to ensure staff received regular supervision.**

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Appropriate systems were not in place to ensure accurate records were maintained of people who lived at the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were not sufficient to meet the needs of people who lived at the home safely.

The enforcement action we took:
We issued a warning notice in relation to this regulation.