Review of compliance

Fountain Nursing & Care Home Limited Fountain Nursing and Care Home Limited	
Region:	West Midlands
Location address:	11-17 Fountain Road Edgbaston Birmingham West Midlands B17 8NJ
Type of service:	Care home service with nursing
Date of Publication:	January 2012
Overview of the service:	The Fountain Nursing and Care Home can accommodate up to twenty-seven people who may have social care and/ or nursing needs.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Fountain Nursing and Care Home Limited was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Fountain Nursing and Care Home Limited had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 17 October 2011, carried out a visit on 8 December 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out this review to check on the care and welfare of people using this service.

We spent some of our time watching what was going on in the home to help us understand what it was like for the people living there. We saw that there were good relationships between the staff and the people living in the home. Staff were friendly and respectful when speaking to people. They were able to communicate effectively with people.

We spoke with some of the relatives of the people living at the home. Their comments included:
'Quite happy with the home.'
'I am very happy, good staff always ready to answer questions.'
'Care second to none.'

People were able to have a choice of food. Any specific diets were catered for, for example, medical diets. The way staff were serving people's meals could be improved to ensure people can enjoy their food.

We saw little evidence of any social activities taking place in the home.

There was a well trained, stable staff team at the home which was good for the continuity

of care of the people living there.

What we found about the standards we reviewed and how well Fountain Nursing and Care Home Limited was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People receive care and support that meets their needs and people are happy with the care they receive. The risks to the safety and well being of people are not always managed appropriately.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

There are systems in place to monitor the quality and safety of the service provided. Improvements are needed to ensure there are systems in place to ensure people's ideas and views are listened to and acted on.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Some of the people who lived at home had dementia and were not able to tell us about their care. We spent some of our time watching what was going on in the home to help us understand what it was like for the people living there.

We saw that there were good relationships between the staff and the people living in the home. Staff were friendly and respectful when speaking to people. We saw that staff offered people help with their personal care discreetly. We saw that some people stayed in their rooms and were being nursed in bed. Staff visited them regularly throughout the day to ensure their personal care needs were being met.

English was not the first language of some of the people living at the home. We saw that some staff were able to communicate verbally with some of the individuals. Other staff were able to tell us how they communicated with the individuals so they could ensure their needs were met. They used gestures and specific words that people understood. They also had access to a communication book with pictures to help them understand what people needed or wanted.

The people we were able to speak with expressed satisfaction with the service they were receiving. To further help us understand what it was like for the people living in the home, we also spoke with some of their relatives and friends after our visit. All the comments we received were positive about the care at the home. Comments included:
'No problems at all can't fault them at all.'
'Let us know when he is unwell.'

'Staff are very, very good. If you want to know anything they always have time for you.' 'He gets a lot of fuss and attention, first class.'

We found that arrangements were in place to ensure that people's nutritional needs were being met. We found that risk assessments had been done and that special diets were provided to maintain people's health and ensure their cultural needs were being met. Where people had lost weight advice was sought from the dietician. We saw that people could have their meals in the dining room or in the lounges and that staff were available to give assistance where needed. We did see that people's hot puddings were served at the same time as their meal. This meant they were going cold while people were eating their first course and they would not be as enjoyable. This was to be addressed by the staff at the home. People that were able told us they were satisfied with their meals.

There were few records of any social activities taking place in the home. Those seen indicated people had visits from friends and families, listened to music and took part in light activities. Staff told us there were activities at least three times a week. This was not evident from the records. People had care plans for their preferred social activities but records did not support these were taking place. For example, one person's care plan stated they liked to read their bible and listen to religious music. This person could not remember if this happened and there were no records to evidence that it had.

Staff told us they received regular training in a variety of topics including moving and handling, health and safety and food hygiene. They were satisfied that the training they received was appropriate to their work roles and equipped them to meet the needs of the people living in the home. Several of the staff had worked at the time for a considerable time. This was good for the continuity of care of the people living in the home.

Other evidence
During our visit, we reviewed the care files for three people to ensure they had the required care plans, risk assessments and management plans in place to ensure their needs could be met and they were kept safe.

Care plans varied in how detailed they were. The guidance for staff was not always enough to ensure staff supported people consistently and in the way that people wanted. For example, staff we spoke with were able to tell us that one person needed creams for their skin and oils for their hair but this was not detailed in their care plans. Another person had a care plan detailing what staff should do in the event of a seizure. This did not include information about when staff should call for medical assistance. The staff we spoke with were able to tell us when they would do this. However it could not be assured that this was correct or if all staff would think the same.

We saw that people had a variety of risk assessments and management plans in place. In most cases where a risk had been identified, there was a management plan in place. For example, one person was at high risk of developing sore skin. A plan was in place showing staff how to reduce the risk of this happening.

People had manual handling plans in place. These were generally well detailed and stated how people were to be moved safely and what equipment was to be used. One person had an activity plan that detailed a different size sling for transfers than was

detailed in the moving and handling plan. Discussions with staff showed the sling size in the moving and handling plan was the correct one. This inconsistency left this person at risk of not being moved safely.

The files we reviewed and our discussions with staff indicated that two of the people living in the home had some behaviours that were difficult to manage. For one person, the care plan stated 'can be aggressive and hit out take time to talk and explain.' Talking to staff, this person was difficult to manage during assistance with personal care on an ongoing basis. There were no specific records of any incidents of difficult behaviour. There was no evidence of a detailed management plan for this to inform staff how to manage the behaviour safely. Staff told us how they managed any incidents and what they told us was consistent. However, it could not be established what was being done to ensure these were the most effective and safe methods or what could be done to avoid the behaviours happening.

Records showed people had access to a range of health and social care professionals both within the community and those that visited the home. This included general practitioners, community nutritional nurses, dieticians, chiropodists, dentists and opticians.

Our judgement
People receive care and support that meets their needs and people are happy with the care they receive. The risks to the safety and well being of people are not always managed appropriately.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke with some of the relatives of the people living in the home. They told us they were kept up to date with what was happening in the home. They told us staff were always ready to answer any of their questions.

Satisfaction surveys were issued to relatives and professionals on a yearly basis. We reviewed some of these comments included:
'We have visited the home on a professional basis over many years. The staff are always polite and courteous to ourselves and residents alike.'
'Really happy and pleased with the care.'
'Very happy with X's placement at Fountain and nursing and care home.'

Some of the relatives had answered 'no' to some of the questions around awareness of the complaint procedure and involvement in the planning of care. It was not clear what was done with this information and how any improvements were made. The provider told us they compiled a summary of the surveys and send this out to relatives. This was not seen.

We could not see how the views of the people living in the home were obtained with a view to improving the service. We were shown the minutes for the meetings held with the people living in the home. It appeared from the minutes that the meetings were discussions about individual people and discussed topics including care and medicines. We were told this was not what happened and people would not be discussed in front of others. We could not be sure what the structure of the meetings were.

Other evidence
We visited the home in October 2011 as we had received some information that indicated the hoists and wheelchairs being used in the home were not well maintained. During the visit in October, we saw records that indicated the hoists were serviced on a regular basis. Regular in house safety checks were also undertaken and recorded on hoists and wheelchairs.

During our visit in December 2011, we found that there were a range of systems in place to monitor and manage risks to the health and safety of people using the service. For example, the recording of water temperatures from the taps and showers were being monitored to ensure people were not at risk of scalding.

We also found fire records showed that most of the equipment was tested as required to make sure it was working. For example, fire alarms and emergency lighting. There had been some lapses in the checking of the fire alarm earlier in the year but this had been addressed. There were regular fire drills so that all staff and the people living there would know what to do if there was a fire.

There were systems in place to audit other processes and procedures in the home to ensure they were improved where necessary. Examples of audits included medicine management and care plans. We spoke with a nurse from the PCT who had been involved with auditing some of the care plans at the home. They told us they had highlighted that some of the documentation needed improving. The staff had listened and this was being addressed.

Our judgement
There are systems in place to monitor the quality and safety of the service provided. Improvements are needed to ensure there are systems in place to ensure people's ideas and views are listened to and acted on.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People receive care and support that meets their needs and people are happy with the care they receive. The risks to the safety and well being of people are not always managed appropriately.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People receive care and support that meets their needs and people are happy with the care they receive. The risks to the safety and well being of people are not always managed appropriately.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People receive care and support that meets their needs and people are happy with the care they receive. The risks to the safety and well being of people are not always managed appropriately.	
Accommodation for persons who require nursing or personal care	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: There are systems in place to monitor the quality and safety of the service provided. Improvements are needed to ensure there are systems in place to ensure people's ideas and views are listened to and acted on.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There are systems in place to monitor the quality and safety of the service provided. Improvements are needed to ensure there are systems in place to ensure people's ideas and views are listened to and acted on.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There are systems in place to monitor the quality and safety of the service provided. Improvements are needed to ensure there are systems in place to ensure people's ideas and views are listened to and acted on.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of

compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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