Bupa Care Homes (ANS) Limited

Collingwood Court Nursing Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Collingwood Court Nursing Home provides accommodation and nursing care for up to 80 older people, some of whom had dementia. There were 79 people living in the service at the time of the inspection.

This inspection took place on 29 February and 2 March 2016 and was unannounced. We last inspected the service on 8 and 9 June 2015 when we identified shortfalls and breaches of the regulations. We found that staff did not receive appropriate support and supervision to enable them carry out their duties effectively and that accidents and incidents were not recorded and reported appropriately. The service received an overall rating of requires improvement.

The service had a registered manager. 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.

People were not always protected from abuse or the risk of harm. Accidents and incidents were not always recorded and the system to identify their occurrence was not robust. The service did not always raise safeguarding concerns appropriately.

People were not protected against the risk of unsafe medicine management We found errors in recording medicines administration and in stock control. However, medicines were stored safely.

People were supported by sufficient numbers of care staff and registered nurses to ensure their needs were met. The service carried out comprehensive recruitment checks prior to staff commencing employment.

Care records directing staff to use restraint were not written in line with the provider's policy because health and social care professionals had not been involved, consent or best interests had not been considered and staff had no training in remaining techniques.

People were supported to make informed decisions. The service worked in accordance with the mental capacity act 2005 to seek authorisation for deprivation of liberty safeguards.

The service was not always caring and some people's bedrooms were not a place of privacy. Several people living at ground floor level could be viewed by the public outside because the service had taken away their net curtains several months before and not replaced them.

We observed staff providing people with kind and sensitive support. Confidential and personal information was stored appropriately.

People were involved in the development of their personalised care plans which reflected their preferences

for care and support. These were regularly reviewed. People were supported to participate in a range of activities.

Staff were unsettled by the high turnover of managers at the service. Conflict existed between staff at the service which was described as 'bullying' and which had not been dealt with by the registered manager. The registered manager did not feel supported by the provider to address their concerns about the attitude of some staff.

Quality and safety audits failed to identify errors in medicines, care records, accident reporting and safeguarding.

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 safe. People were at risk because accidents were not appropriately recorded and investigated

People's medicines were not always managed safely and errors in medicines administration were not identified and addressed.

People were at risk because safeguarding reporting processes were not correctly followed.

People had detailed risk assessments that were personalised and reviewed regularly.

Is the service effective?

Requires Improvement

The service was not effective. Care records directing staff to use restraint were not written in line with the provider's policy because health and social care professionals had not been involved, consent or best interests had not been considered and staff had no training in remaining techniques.

Staff were supervised and received the training they required to deliver care and support.
People's nutritional needs were assessed and they were provided with the level of support they required to eat and drink enough.

People were supported to access healthcare professionals as their needs required.

Is the service caring?

Requires Improvement

The service was not caring. People's privacy and dignity were not always respected. People could be viewed in their bedrooms by passers-by because the service had removed net curtains and not replaced them.

People told us the staff were caring and we observed staff being kind and compassionate.

People's care records were stored safely and confidential information was protected.

Is the service responsive?

Good

The service was responsive. People's care plans were personalised to meet their individual needs. Staff understood people's preferences for care and support.

People were supported to take part in activities and to maintain relationships that were important to them.

Is the service well-led?

Requires Improvement

The service was not well-led. Unmanaged conflict existed within the team with the treatment of a number of nursing staff by care staff described as "bullying".

The manager did not feel supported by the provider to address the attitude and behaviour of some staff.

The service's quality audits failed to identify and address errors in medicines and guidance in care records and failings in the reporting of accidents and safeguarding concerns.

Staff thought the manager was open and approachable.

The provider gathered the views of staff

Collingwood Court Nursing Centre

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 29 February and 2 March 2016 and was unannounced. The inspection was carried out by two inspectors, one pharmacy specialist advisor and a nursing specialist advisor.

Prior to the inspection we reviewed the information we held about Collingwood Court Nursing Home, including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with 14 people, two relatives and 4 healthcare professionals who were visiting the service. We also spoke with the registered manager, 10 nurses, 12 care staff and the catering manager.

We reviewed care records for 21 people, including their needs assessments, care plans and risk assessments. We case tracked 11 people. We checked how medicines were managed and we read 14 people's medicines administration records. We read the provider's auditing records used to monitor the quality and safety of the service. We check staff records including information relating to recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that the service was not safe because staff did not always report adverse events or incidents. We made a recommendation to the provider to seek support and training for staff in relation to report and recording of incidents.

At this inspection we found that although staff had received training and support, accidents were not recorded appropriately. On the first day of our inspection we observed that a person had a bruise on their forehead and small cut which was healing. We reviewed the persons care records and did not find any reference to the injuries in the persons care plan, accident and incident records or daily notes. We did locate a body map which was undated but contained no details besides 'bruise on forehead'. We were informed that accident reports were not retained on the unit but passed to the manager's office. The registered manager and deputy confirmed they had not received a form in relation to the case we identified. This meant people were at risk of accidents not being reported, investigated and analysed.

We reviewed the service's safeguarding notifications. We found that in one case the provider did not follow its own procedures in the reporting of a safeguarding concern to the local authority. Incorrect information had been included in documentation forwarded to the safeguarding team and in turn the police which resulted in an investigation being closed without an outcome. The provider's internal investigation into the failings of the safeguarding alert concluded that the senior member of staff did not understand the provider's or local authority's safeguarding reporting procedure. This meant people were at risk of abuse not being reported.

The above is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were placed at risk of unsafe medicines management. Medicines audits did not always identify errors. We reviewed the medicines administration record (MAR) charts and medicines stocks for 14 people. We found discrepancies in 10 cases. Three people had MAR charts which showed staff had signed to confirm they had administered medicines but the balance of medicines showed that people had not received them. For example, records for one person showed that on 16 occasions staff incorrectly signed to confirm that medicine was administered. We found that four people had received medicines which had not been appropriately signed. For example, the MAR chart for one person's 'when required' medicine recorded that it had been administered on nine occasions but when we checked the balance of medicines it showed that 11 doses had been administered. This meant people were at risk of not receiving the right medicines at the right time. We found one person's MAR chart was hand written and did not contain their name. Another person had a hand written entry that did not state the strength of the medicine they were prescribed. We found one instance of a medicine not given and not signed. This meant there was a risk that medicines were might not be administered to the right person at the right dose.

This is a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Medicines were stored securely and environmental checks were in place which included the recording of room and medicines fridge temperatures. People's allergies were recorded on the front of their MAR charts and the same information was recorded in their care records. People receiving covert medicines were supported with mental capacity assessments and staff had clear guidance in care records.

People told us they felt safe. One person said, "I'm fine. I'm safe. I'm not worried about being in here." Staff confirmed they had undertaken training in safeguarding and they were able to tell us the signs of abuse they would look for and the actions they would take if they suspected someone had been abused. A member of staff told us, "I would report it to a senior [member of staff] straight away." Staff we spoke with understood the provider's whistle-blowing procedure. Whistleblowing is a term used when staff alert outside agencies when they are concerned about the provider's care and support practice. One member of staff told us, "If I saw any bad practice I would tell the nurse in charge and the manager. If they didn't do something about it, I would take it outside and let the external people deal with it."

People were protected against the risk of avoidable harm. People's risks were assessed and risk management plans were written to address individual needs. Risk assessments were written by the service's nurses with the involvement of people, families and healthcare professionals. Risk assessments were reviewed monthly or when people's needs changed for example, following a fall. A member of staff told us, "When we assess falls risks we are asking a number of questions: is there a deterioration in mobility or vision? Is there an underlying health issue or is the environment the issue?" Care records showed that staff took action following falls, including making referrals to healthcare professionals for mobility assessments and the provision of equipment such as walking frames.

People were protected against the risk of pressure ulcers. Each of the service's three units had a member of staff designated a 'pressure ulcer champion.' Their role was to promote good practice in skin care and vigilance in the prevention and detection of pressure ulcers. At the time of the inspection there were certificates of achievement on display awarded to the service for 100 days without a pressure ulcer. Records showed that when people were admitted into the service with pressure ulcers, timely referrals were made to tissue viability nurses and the GP. Additionally wound care plans were written, updated daily following each dressing and reposition charts were introduced.

People were supported by sufficient numbers of staff to meet their needs].One person told us, "There are always plenty of carers about." A relative told us, "I have never come here, looked about and thought there aren't enough staff." We looked at rotas which showed there were sufficient numbers of staff to meet people's needs. The registered manager explained that staffing levels were decided by people's needs. A dependency tool was used to determine when staffing numbers should increase and rotas confirmed this. We saw that care and nursing staff were available to people throughout the service. We observed staff responding promptly when a person used the call bell in their bedroom.

People were protected by the provider's safe recruitment practices. Staff records showed that the provider had carried out pre-employment checks before staff were permitted to provide care and support. Checks included identification, eligibility to work in the UK and references from previous employers. Staff completed checks with the Disclosure and Barring Service (DBS) who check details about criminal records and those prevented from working with vulnerable people. This meant people were protected against care and treatment being provided by unsuitable staff.

A healthcare professional visiting the service during the inspection told us that they had observed staff supporting people using manual handling equipment. They confirmed staff had undertaken checks before using hoists and had used the equipment correctly.

A member of staff told us, "We are trained in the use of different equipment to support people's mobility and transfer needs. It could be from chair to chair or wheelchair to toilet or into or out of bed. We follow what is in each care plan. When a person requires a hoist we use two staff." We observed staff supporting people's mobility and transfers appropriately and in line with their care plans.

The service employed two maintenance staff. Maintenance staff undertook checks on the safety of the building and equipment and carried out repairs when necessary. The registered manager audited the environment each week and produced an action plan to address areas for improvement.

People told us the home was clean. The service had a cleaning team who worked to a cleaning schedule and their work was audited. We observed staff using personal protective equipment appropriately. During the inspection we observed the home to be clean and odour free. Records showed people with hospital acquired infections were supported with care plans. All staff undertook hand hygiene and infection control training. This mean people were protected against the transmission of healthcare associated infections.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that staff were not adequately supported and supervised. Staff were not receiving regular supervision from their line managers to fulfil their roles effective. During this inspection we found that a supervision and appraisal programme had been introduced. The registered manager supervised department heads and unit managers who in turn supervised their subordinates. Nurses were supported with clinical supervision to discuss people's care and treatment. We read in supervision records that staff knowledge was tested by the supervising manager. For example staff were asked questions including 'What would you do if food or fluid is refused?' 'What are the symptoms of a hip fracture? 'Why is it important for two staff to sign position change charts? 'The registered manager took into account staff responses when planning training and assessing competences. This meant people received care from staff who had their knowledge and skills monitored by managers.

People were supported by staff who had the skills and knowledge to provide effective care. People and their relatives told us that staff were experienced and knew people well. One person told us, "They know how I like to be looked after." A relative said, "They [staff] are very professional. They know exactly what they are doing."

People were supported by staff who had undertaken an induction. New staff received one weeks' induction training which included shadowing staff. During the three weeks following their induction new staff were allocated a 'buddy' from amongst their established colleagues. The role of a buddy was to act as a mentor to new staff and aid their understanding of people's needs and preferences. A member of staff told us, "I felt confident after my induction. I knew people and the care plans as well as staff and the procedures here." The deputy manager assessed the competency of staff following their induction to ensure they were capable of delivering care to people independently.

Staff received on-going training to enable them to deliver care and support effectively. We read that training included manual handling, first aid and dementia awareness. Records showed that 60% of staff received mental capacity act, deprivation of liberty safeguards and safeguarding training during November and December 2015. Further sessions were planned for staff who did not attend. Nursing staff attended tissue viability training and had their competency tested yearly. We checked the records of five nurses and found all five had had their competency tested since November 2015. This meant that people received care and treatment from staff whose skills were up to date.

The registered manager understood their responsibilities in relation to the mental capacity act 2005 (MCA). The MCA exists to protect people who may lack capacity and to ensure that their best interests are considered when decisions that affect them are made. People can only be deprived of their liberty when it is in their best interests and legally authorised under the MCA. The application procedures for depriving people of the liberty in care homes are called deprivation of liberty safeguards. The registered manager had identified were DoLS authorisations were necessary. Four people were subject to authorised DoLS and a further four people were awaiting an assessment. The registered manager had issued staff with laminated cards, to be kept on their person, containing information about the mental capacity act. Each person's care

plan contained a flow chart showing how people's choices and decisions over care were made. This meant that staff knew when advocates were needed, when best interests' meetings should take place when a person needed to have their mental capacity assessed.

People were at risk of physical harm and having their liberty being deprived. Two people's care records stated that they could be restrained by two staff if their behaviour was challenging. There was no evidence of a mental capacity assessment about this specific intervention. Neither person's care records stated the specific circumstances in which restraint could be used or whether it was a proportionate response. There was no guidance for staff about the restraint technique to be used, or how long people should be restrained for. Staff had not been trained in the use of safe restraint and the registered manager confirmed that no restraint training was planned for staff. The provider's policy stated that restraint should never be used unless its use is agreed in advance on a multiagency basis. The registered manager confirmed that health and social care professionals were not involved in the decision to use restrain techniques with either person. This meant that people were at risk of physical harm and their liberty being deprived by staff attempting to restrain them without appropriate training, guidance or consent.

This is a further breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's nutritional needs were met. People told us they liked the food they received, had choice and were served enough. One person told us, "There is always plenty to eat, there's a menu on the table so you know what you can have." Another person told us, "The food's good, we are given a choice." Menus displayed photographs of each dish. This meant people were given visual cues to assist their decision making. The catering manager told us, "At admission we look at allergies and special diets. For example at the moment we support a number of people who have pureed diets. They get the same choices but pureed to be safe for them to swallow".

People who required support to eat received it. Care records for people on one unit showed 11 people had been assessed as needing one to one support to eat. We observed people eating lunch and saw each person who required individual assistance to eat and drink were supported by staff in line with their care plan. For example, one person's care records stated that their fluids should be thickened to prevent against the risk of aspiration and detailed the position the person should be seated whilst drinking. We observed staff implementing these guidelines whilst delivering care. We saw that fluid charts were introduced when there were concerns that a person was at risk of dehydration.

People were supported to access healthcare resources as their needs required. A supporting GP practice visited the service three days a week. People were also supported by staff to access their own GPs when they chose. Healthcare professionals told us staff followed their instructions for the delivery of care and treatment. Records showed timely referrals had been made to healthcare professionals for example physiotherapists, tissue viability nurses. Healthcare professionals told us staff followed their advice for the delivery of care and treatment. For example, staff followed guidelines on supporting a person's mobility by using the recommended equipment in the way the healthcare professional had directed.

Requires Improvement

Is the service caring?

Our findings

We observed that staff gave some consideration to people's privacy and dignity. We saw staff knock on people's bedroom doors, including those that were held open, but did not always wait for people to respond and invite them in before entering. Some ground floor bedrooms did not have net curtains on their windows. This meant when people's curtains were open members of the public could view people directly in their rooms. People told us they did not like this. One person said, "It's just not on really is it?" Staff told us that nets had been removed several months previously and that not all had been replaced. A member of staff said "Where's people's privacy? The nets were taken down to be washed and some weren't put back. I've lost count of the number of times we've raised this. I would hate people staring at me in bed." There was no evidence in care records of people consenting to having their net curtains removed.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had not ensured people were treated with dignity and respect.

People told us staff were kind and caring. One person told us, "The staff are all very good but [staff name] is my favourite, she really makes a difference to my day." Another person said, "The [staff] are good, usually polite, I would recommend the home." A third person told us, "Staff treat us well."

Throughout the inspection we observed that people looked at ease and staff responded to them with patience and understanding. For example, during a thunderstorm a number of people were visibly frightened. We saw staff showing people compassion by offering gentle reassurance, holding hands with people who sought comfort and speaking softly to them until the storm passed.

People were supported to a maintain relationships with their families and friends. Relatives told us they were made to feel welcome when the visited and were invited to events to mark special occasions such as birthdays. Some elements of people's care were undertaken by family members. For example, some relatives assisted people to eat their main meals each day and this was recorded in care records to ensure the support had been provided.

People told us they were involved in making decisions about their care and support. One person told us, "My family and myself are involved in my care, I go out when I want to go out." Another person said, "I have a bath when I like or I can have a shower."

People's care records were stored securely in each unit. The personal information contained within care records and medicines administration records were not accessible or visible to visitors. This meant that people's confidentially was protected.

People had personalised end of life care plans detailing their wishes for end of life care.
A member of staff told us, "We try to make the end of life as comfortable as possible for people and their relatives. Death should be pain free and we manage that. We make sure people drink plenty of fluids and are turned frequently. We make sure people are warm and if they want we can have music or their TV on. We

respect people's last wishes. This meant that people were supported to have a dignified death.

Good

Is the service responsive?

Our findings

People received care and support that met their individual needs. Staff we spoke with understood people's personal preferences and had knowledge of people's personal histories. Care records contained a section entitled 'my life story' which highlighted facts and experiences which were important to people. People had memory boxes beside their bedroom doors containing items of significance to them for example military service medals and wedding photographs. People's photographs were displayed on their bedroom doors to personalise and identify their rooms.

People's needs were assessed prior to moving into the service to ensure their care and support was planned. Care records detailed how staff should support people and were personalised to meet individual needs. People's comments and those of their relatives were clearly documented. Care records were reviewed and updated to reflect changes to people's needs. We found that referrals to healthcare professionals were made promptly as changes in needs were identified. For example, we saw the involvement of a dietician to assess and support a person in response to a drop in their weight.

People told us there were activities available for them to participate in. We observed an art session delivered by the activities coordinator to 14 people. People were encouraged to paint flowers picked from the garden specifically for the session. We saw people encouraged to smell the flowers and say what they thought of them. People who did not want to paint flowers were given alternative ideas or made their own choices about what to draw. Staff engaged with people individually throughout the session. People were supported to access the garden when the weather permitted. For people who chose to there was a supervised smoking area in the garden. Staff supported people to purchase daily newspapers of their choice. A hairdresser attended the service each week and entertainers occasionally visited the service. For example, an opera singer was due to perform in the service a few weeks after the inspection. People are supported to participate in faith activities as they choose. Catholic, Methodist and Baptist Church services are held each week.

People and their relatives knew how to make a complaint. The provider had a complaints procedure which detailed how complaints should be managed. We read that complaints were recorded, investigated and complainants given a written response.

The relatives of people who used the service had a committee which held meetings with the registered manager and other service representatives. Minutes of these meetings were made available for people, families and staff. Meetings were used to identify areas of improvement and obtain feedback on the quality of care to date. We read in the minutes of one meeting a relative say "the nursing is brilliant".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the service did not have a registered manager. At this inspection the service had a registered manager. Staff told us that the service has had five managers in two years. Staff described the frequent changes of manager as unsettling and said the absence of continuity and leadership had a negative impact on morale and cohesion within the team.

At this inspection we found that conflict within the staff team had not being effectively managed. A healthcare professional and several staff used the term 'a culture of bullying' when describing the relationship between care staff and nursing staff. Several staff made references to nurses being intimidated and ignored by care staff. During the inspection we noted a person had long and unkempt finger nails. We read their care plan which stated the person required assistance to cut them. We brought this to the attention of a nurse who reminded a member of care staff that they had already been asked to undertake this task and record that they had done it. The nurse told us they were glad we raised the issue as it was difficult to get care staff to follow instructions. The registered manager confirmed that there was conflict in parts of the service but did not feel supported by the provider to effectively address it.

At our last inspection we found that whilst the service had introduced a number of quality audits these did not always identify the issues they were designed to detect. At this inspection we found that medicines audits failed to identify medicines errors. We found a failure in the process for reporting accidents and incidents and a further failing in the reporting of a safeguarding concern.

This is a breach of Regulation 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Records of staff training and when refresher training was required were kept and nursing competence records maintained. A scheduled of environmental checks was up to date. People's daily records were accurate and people's risks were monitored. For example, the manager ensured that people at risk of weight loss had their weight recorded and if a person was identified as having lost two kilograms in one month a referral was made to the GP and dietician. The recording of their weight was increased to weekly.

Management arrangements within the home were clear. The staffing structure provided lines of responsibility and accountability. The manager and deputy manager met daily with unit heads and clinical leads. Each day unit managers hold a short meeting with staff entitled 'take 10'. These were used to share feedback from people and provide updates on people's changing needs. For example, staff discussed high risk clinical issues resulting from changes to a person's healthcare needs.

The provider sought the views of staff. We read that the most recent staff survey had 78% response rate. Results from the survey included 91% of staff felt they had the training they needed to do their job well.

The service worked with other agencies to meet people's care and support needs. Referrals were made to healthcare professionals to ensure people received effective care and treatment. The service liaised with hospitals and the local authority to support people's assessments and admission into the service.