Bupa Care Homes (CFChomes) Limited

Cold Springs Park Residential Home

Inspection report

Cold Springs Park
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Cumbria
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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out this unannounced inspection on 23 September 2105. We last inspected this service in March 2014 and looked at six of the essential standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were all compliant. These Regulations have now been replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found breaches of Regulation 12 Safe care and treatment and of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cold Springs Park Residential Home (Cold Springs Park) is located in the town of Penrith and is owned by BUPA. The

Summary of findings

home provides residential care for 60 elderly people and is divided into two units, Cold Springs unit and Spring Lakes unit. Spring Lakes unit supports people living with dementia.

There was a registered manager employed at the service. 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.

Although people told us that they felt safe receiving care and support from this service we found that some care plans and records relating to people's current needs and risk assessments were not consistent. We found that information about some people's care needs had not always recorded. Newly implemented care planning records for some people were not seen to be fully effective.

Concerns found during the visit about the safety and wellbeing of some people in the home led the inspectors to share information with the local authority safeguarding team.

Staff were aware of their role in safeguarding procedures they knew how to identify and report concerns about a person's safety. Staff received training to ensure they could meet people's needs including training in how to keep people safe. A staff training programme was in place to ensure that staff were trained to carry out their role and the provider had plans in place for updates and refresher training.

The provider was in the process of recruiting more staff to work at the home. Staff told us that the levels of staff both during the day and at night were not always sufficient. The numbers of staff available during the night meant some people had been asked to alter their routines.

The records for the management of medications and prescribed creams in the home were not always accurate. Systems in place could not ensure that people received their medication safely. Information relating to the risks associated with some medications were not always documented.

Requirements that ensure where decisions are made in people's best interests when they are unable to do this for themselves had not always been followed.

People were supported with their nutritional needs but where someone had significant weight loss referrals to healthcare professionals were not always made.

Staff displayed a caring and interactive approach with people and they were treated with respect. People dignity and privacy were promoted.

There was an activities programme in place and people were given opportunities to be involved in hobbies and interests that were important to them.

The provider had a complaints procedure available for people who used the service and complaints were appropriately managed. People who used the service and their families felt able to raise any concerns they might have with the registered manager or other staff members.

Not all staff felt that the atmosphere of the home was open and inclusive. Some staff felt that they were not always listened to by the registered manager. Staff told us they received a lot of support from the deputy manager and unit managers.

The registered manager and provider had systems in place to monitor the service but this was not always effective in bringing about improvements or protecting people from potential harm.

We recommended that the service considered the consistency of the quality of their care planning to ensure that accurate information is recorded about the needs of people who used the service.

We recommended that appropriate records are completed along with obtaining and recording people's consent in line with legislative guidance.

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

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?
The service was not always safe.

The records relating to the safe management of medications were not consistent and for some people risks relating to their medicines had not been identified.

Risks associated with changing needs and providing safe care were not always identified or recorded.

New staff were checked to ensure they were suitable to work in people's homes.

Requires improvement

Is the service effective?
The service was not always effective.

Records relating to people's nutritional requirements were not always accurate.

All the staff employed by the service had completed training to give them the skills and knowledge to support people.

Records required when making decisions in people's best interest had not always been made.

Requires improvement

Is the service caring?
The service was caring.

The staff were caring and respectful and maintained peoples dignity.

People said they liked the staff who supported them.

People's wishes and preferences had been made clear in their records about what their decisions were for end of life care.

Good

Is the service responsive?
The service was not always responsive.

The consistency of the quality of care planning did not ensure that accurate information was recorded about the needs of people who used the service.

Not all reviews of people's changing needs were accurately recorded.

Systems and processes were in place to manage concerns, incidents and complaints.

Requires improvement

Is the service well-led?
The service was not well-led.

Staff were not confident with the support from the registered manager.

Requires improvement

Summary of findings

The registered manager had not always contacted the appropriate authorities in a timely manner when concerns had been raised.

System in place to monitor the quality and safety of the service were not always effective applied in the home and acted upon by the registered manager.

Cold Springs Park Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out this inspection on 23 September 2015. The inspection was unannounced. The inspection was carried out by two adult social care inspectors and an inspection manager.

Before the inspection we reviewed the information we held about the service. This included information of concern from a member of the public and based on our collective information we brought forward the date of the inspection of this service. We asked the provider to complete a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also asked for information about the service from the local commissioners.

During the inspection we spoke with the registered manager, customer service manager, deputy manager and ten staff members, including kitchen and domestic staff. We also spoke with people who used the service and two relatives. We observed how staff supported people who used the service and looked at all the care records for eight people living at Cold Springs Park.

We looked at the staff files for staff that had been recruited. These included details of recruitment, induction, training and personal development. We were given copies of the training records for the whole team. We looked at records of maintenance and repair, the fire safety records, food safety records and quality monitoring documents. We also looked at records relating to how complaints and incidents were managed and how the provider checked the quality of the service provided.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, ''Oh yes, I feel very safe with all the staff. They (staff) are all good and help me whenever I need it.'' Another person told us, ''I have never been ill-treated and I would say if I had''.

Staff told us that they knew how to identify abuse and told us they would confident to report any concerns to their seniors and mangers. During our inspection concerns were raised by staff about a recent event that had been notified to the registered manager and that some staff felt this had not been managed effectively. Information about people who may have been at risk of harm had not been shared in a timely manner.

Staff told us, and records we looked at confirmed, they had received training in the safeguarding of adults. There was a whistle blowing policy that was available to all staff and details of how to report concerns.

We looked at eight people's care records in detail for the management of their medications and found that following their admission assessment no further care plans had been made of some people's current medications. For some people there was no care plan devised on how to manage their medications or records to identify any risks that might be associated with their medications. For example where someone required blood thinning medication there was no care plan or risk management plan in place should any side effects occur. This is particularly concerning as this is considered a high risk medication that requires carefully monitoring to ensure its safe administration.

We also looked at the records for the administration of prescribed creams and found that these were not consistently recorded and for some the instructions for how the creams should be applied was not always accurate.

All the staff we spoke with said they had completed training in the safe handling of medicines. Records we looked at relating to the quantities and stock of some medications were not always correct. This made it difficult to be certain that the correct amounts of medications had been given as prescribed.

This was a breach of Regulation 12 (g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report. Because the provider had not ensured that people's medications were being safely and effectively managed.

We looked at a total of eight care records for people. We saw that some hazards to individuals' safety had been not always assessed and measures were not always recorded that had been put in place to reduce or manage the risks identified. For example where the use of sensor mats or bedrails were required to keep people safe the care records did not always identify the use of these. Where people had fallen their care records had not been reviewed to reflect any changes that may be required to prevent further falls.

One person's care records were not reflective of most of their changed needs following a fall. This person's deteriorating health and unrecorded current needs caused the inspectors to report their concerns to the local authority safeguarding team.

This was a breach of Regulation 12(1)(2)(a) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People who used the service and the relative we spoke with said they felt there was sufficient staff to provide the support people needed. All the care staff we spoke with told us about their concerns

in relation to the numbers of staff on each shift and the overall availability of staff. A number of staff reported they had worked extra hours on a regular basis to ensure the minimum of staff were on shift. We discussed this with the registered manager who had identified that staffing levels were not currently ideal. We were told and saw that the provider and registered manager had a plan of action in place to address the recruitment of staff and some new staff were soon due to start employment. The registered manager assured us that the staffing levels were based on the dependency of people's needs and people were safe.

During our inspection we saw most people did have their needs met in a timely manner however there were times where staff were not visible in busy communal areas of the home especially during the morning routines. We were also told by people that to assist the staff on nights with their permissions they would be got up earlier and be assisted to

Requires improvement

Is the service safe?

bed earlier. This meant that the levels of staffing were not always sufficient to meet individual's preferences and that the service being delivered was more tasks orientated than person centred.

We looked at the records of accidents and incidents that had occurred and saw where necessary notifications to the appropriate authorities had been made. However not all the care records we looked at showed what actions that had been taken in response to these incidents to promote the safety and wellbeing of people who used the service.

We looked at seven staff files for recruitment and saw that the appropriate checks of suitability had been made. References had been sought and we noted that they were usually from the most recent previous employer in accordance with the provider's recruitment policy. Checks with the Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had also been conducted.

Requires improvement

Is the service effective?

Our findings

People who lived in the home told us that they thoroughly enjoyed the meals provided. One person told us, "The cooks are excellent and food is really good." Most people chose to eat in the main dining room and a few people chose to eat in other areas in the home. We saw people could attend breakfast at their leisure and received the right level of assistance they needed to eat and to drink. We saw that this was provided in a patient and discreet way.

For all but one of the people's care records we looked at nutritional assessments had been completed and where people had additional needs or required additional support they had been referred to the appropriate health care professionals. Care records showed that for most people nutritional risks had been assessed and care plans implemented for staff to follow to reduce those risk.

We spoke with the cooks who had a good knowledge of people's differing needs of nutrition. They told us how they used innovative and creative ways to present foods in a different way to ensure people who may require additional needs were catered for. Even though menus were pre-set by the provider for the month they had the budget to cater for individual people's likes, dislikes and any cultural preferences. The kitchen had recently had some upgrades and was adequately staffed. We observed fresh foods were used for meal preparation and the quality of food served was to a high standard.

Where Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) documents in relation to people's wishes and medical decisions about their end of life care had been implemented these did always not contain all the relevant consents or information required to meet NHS guidance. For example one person's document had not been reviewed by a doctor since discharge from hospital over a year ago. A number of the documents referred to family being involved in the decisions having the appropriate legal powers to do so but no one had checked they had.

Where some people lacked capacity to make certain decisions there were no records of any best interest meetings recorded. Some of the care plans we looked at had not been formally consented to. Two people with capacity that we spoke with told us they had never seen their care plans and that they were never discussed with them. This meant records relating to care, decision making and best interest decisions were not always consented to by the appropriate people.

The registered manager and some senior staff did not demonstrate sound knowledge or understanding of the Mental Capacity Act 2005 (MCA) in relation to the requirements around consent and decision making. Training records showed that all staff had completed on line training relating to the MCA 2005 and Depravation of Liberties Safeguards (DoLS).

We recommended that appropriate records are completed along with obtaining and recording people's consent in line with legislative guidance.

The staff we spoke with told us that they received a range of training to ensure they had the skills to provide the support people required. One member of care staff told us, "We're always having training, we get updates all the time". The care staff we spoke with told us that new employees completed mentoring and training before working alone with people. This was confirmed by the induction training records and rota's we looked at.

The care staff told us that they had regular meetings with managers to discuss their practice and things going on in the home. All the staff said that they knew how they could contact any of the managers if they needed advice about a person they were supporting. There was on call person available to the home for any out of hours concerns.

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Good

Is the service caring?

Our findings

People we spoke with living and visiting at Cold Springs Park told us they were very happy with the care and support they and their relatives received. Some of the comments included, “The staff are lovely.” One person told us, ‘’The staff are great bunch and work hard.” Another person told us “They’re (staff) always busy but never too busy to help when I need it.”

We saw from the interactions that staff had with people living in the home that they knew people well and understood each person's needs. Staff knew the life stories of people in the home and were aware of their preferences. We heard staff talking to people about families and friends. We observed that staff interacted with kindness and were respectful of people.

People could access advocacy arrangements if they needed to and staff told us they had supported people in the past to do this. An advocate is a person who is independent of the home and who supports a person to share their views and wishes. We saw that information was available in information leaflets in the entrance to the home for other services that might help people independently.

We observed staff knock before entering people’s rooms. We saw that people were asked in a discreet way if they wanted to go to the toilet. Staff maintained people’s personal dignity when assisting them with mobility and when using mobility equipment they needed. Bedrooms we saw had been personalised with people’s own belongings, such as personal furniture, photographs and ornaments to help people to feel at home.

We saw that people’s care records were written in a positive way and included information about the tasks that they could carry out themselves as well as detailing the level of support they required. This helped people to maintain their skills and independence.

Where it was relevant we saw that people's treatment wishes had been made clear in their records about what their end of life preferences were. The care records contained information about the care people would like to receive at the end of their lives and who they would like to be involved in their care. This was to ensure people who could be involved with planning end of life care were cared for in line with their wishes and beliefs at the end of their life.

Requires improvement

Is the service responsive?

Our findings

We asked the people who used the service whether they felt they could easily raise concerns if they had any. One person told us, "I've never had to make any complaints." Another person told us if they had a problem they felt more than happy to raise it directly with any of the staff. The registered provider had a formal process for receiving and responding to concerns, incidents and complaints about the service it provided. People told us the staff knew the support they needed and provided this at the time they required it. One person told us, ''They look after me very well." Another person told us, ''We have good food, it's clean and all the staff are lovely."

We looked at the care records for eight people. We saw that information for staff about how to support individuals which was not always accurate or consistent. Some of the care plans we looked at had been updated into a new format and staff told us they had transferred information from previous care plans but felt that new care plans were not as informative. However we found that some of the information transferred to the new care plans was not up to date. This was mainly noted on the Spring Lakes unit. We also saw that where changes had occurred in people's needs this had not always been recorded so the care plan did not accurately reflect the support they required.

There were some activities for people to get involved in and we observed people enjoy doing individual activities and a group activity took place where people were supported by staff to join in. There were a wide variety of organised activities and activities coordinators were in post.

We saw that a full assessment of people's individual needs had been completed prior to admission to the service to determine whether or not they could provide them with the right support that people required. We saw that where people could be involved and had reviews of their care they were asked for their views about the support they received. People had been asked what support they wanted the service to provide and records showed that some people had been included in planning their own care.

People told us that they had been asked for their opinion on the services they received. We saw that residents meetings had taken place that included relatives. The minutes of the last two meetings in July & May 2015 recorded under health & safety that levels of staffing needed to be appropriate and reminded staff 'not to work short' but to call the registered manager even out of hours. The home also produced quarterly newsletter sharing information and about planned events and other items of interest.

We could see in people's care plans that there was effective working with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services. We spoke with visiting health care professionals who supported people who lived in the home. They told us that the staff were good at contacting them and asking for advice and made appropriate referrals where necessary.

We recommended that the service considered the consistency of the quality of their care planning to ensure that accurate information is recorded about the needs of people who used the service.

Requires improvement

Is the service well-led?

Our findings

People who used the service and staff we spoke with gave a mixture of positive and negative comments in relation to the service being well led. One person told us, ''I can ask to talk to (first name) the registered manager any time.'' People told us that they knew the deputy and managers well and said they were "approachable" and "easy to talk to". Some staff we spoke with about leadership in the home identified that there had been times when they felt they had not always been listened to or supported by the registered manager. However the staffing structure in the home allowed staff to access other senior managers with any concern's they might have. We also noted that the provider has a system whereby staff can contact senior company staff outside of the home.

The registered manager had experience and knowledge about requirements relating to notifying CQC of all incidents and events that were required under the regulations. The registered manager of the home had usually informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. However during the inspection it was noted that a recent alleged incident relating to the management of some people's medications had not been notified to the appropriate authorities at the time of it being reported to the registered manager at the time of it being reported notified to the registered manager. Information about people who may have been at risk of harm had not been shared in a timely manner.

The provider and registered manager used a range of systems to monitor the quality of the service. There were a number of audits in place that checked on the safety and quality of the service. However we found that despite these being very informative the samples of auditing had not always identified the issues that we had found in the quality and consistency of care planning and safe management of medications.

We saw from the quality monitoring visit in August 2015 completed by the provider's quality manager that actions from care plan audits over three months had not been addressed within a reasonable timescale. The monitoring visit also identified that there had been a sudden increase in occupancy resulting in staff hours needing to being increased. The registered manager had already identified that staffing levels had been short at times in May and July 2015 and had an action plan in place to address the on going recruitment of staff. With this information consideration had not given by the provider and registered manager when admitting more people to the home.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (regulated activities) regulations 2014 as some quality monitoring processes were ineffective. There had been lack of completion of outstanding actions identified for care records. Procedures had not been implemented effectively where the safety of people may have been affected.

We identified concerns about the management of the home and we shared these with the provider. The provider assured us that they would look into the concerns raised by staff. We saw that the deputy manager and unit managers at the time of the inspection had very good oversight of the service. We observed they provided care and worked with staff delivering people's support. This meant that they were regularly in contact with the care staff and with people who used the service and were able to gather their views about the quality of the service on a less formal basis.

The home worked in partnership with other professionals to ensure people received appropriate support to meet their needs. We saw records of how other professionals such as the Care Homes Education and Support Services (CHESS) team had been involved in reviewing people's care and providing the support required by the home. Some people living at the home had regular support from community nurses and the home worked with the community nursing team to meet people's needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Records relating to the safe management and administration of medications were not always accurate. Risks associated with people's needs had not always been assessed or recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes established were not always effective to ensure compliance with the requirements of the regulations.