Bupa Care Homes (ANS) Limited

Collingwood Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Collingwood Court Care Home provides accommodation and nursing care for up to 80 older people, including some living with dementia. The home is split into three units. There were 35 people living at the home at the time of the inspection.

People's experience of using this service and what we found
We found that records in relation to the management of people with pressure sores were incomplete and we could not be assured they were receiving appropriate and safe care. Although people using the service were generally happy with the care and support they received, we received mixed feedback from them about staffing levels within the home. This was reflected in the feedback from staff. Staffing rotas showed there were occasions when staffing levels were not consistent. People told us they felt safe and where concerns were raised, the provider engaged with the safeguarding process. People received their medicines as prescribed from trained staff and infection control practice within the home was safe.

Staff received training relevant to their roles, however they said they did not always feel supported by the managers. People's needs were assessed on a regular basis and they continued to be supported by external health care professionals such as district nursing teams. Healthcare professionals raised concerns about poor communication from the home. The provider had taken these concerns on board and had arranged a meeting with them to see how they could work more closely in future to ensure people received good care, especially in relation to the management of pressure sores.

The COVID-19 outbreak had an impact on staff wellbeing and morale within the home. Staff did not feel respected nor valued. They also said support from managers was inconsistent. This had been acknowledged by the managers of the home and they told us they planned to take steps to understand staff concerns through a series of listening and drop in clinics facilitated by an independent HR employee. There had been some challenges within the home in relation to management cover during COVID-19, regional support was provided to the home during this time. The registered provider failed to submit statutory notifications to the CQC.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update.
The last rating for this service was requires improvement (published 26 October 2019) and there was a breach of regulation in relation to staff training. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had been made and the provider was not in breach of regulation 18 in relation to staff training. However, we found additional breaches of regulation.

The service remains rated requires improvement. This service has been rated requires improvement for the

last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about management of pressure sores, staffing, and the competency of management. A decision was made for us to inspect and examine those risks. CQC have introduced targeted inspections to follow up on previous breaches or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We undertook a targeted approach to review part of the key question of Effective.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Collingwood Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care treatment and notifications of incidents at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement.

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Collingwood Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and a specialist advisor who was a registered nurse.

Service and service type
Collingwood Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 1 hours' notice of the inspection. This was because we were responding to risk concerns, and wanted to be assured that no one at the home was symptomatic in light of the COVID-19 pandemic.

What we did before the inspection
We reviewed intelligence we held about the service, including whistleblowing concerns and feedback from partnership agencies. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people that use the service, a visiting relative, two nurses, eight care workers, two housekeepers, an activities co-ordinator, a receptionist, the registered manager, regional support manager, regional quality manager, regional director and a visiting health professional. We also spoke over the telephone to an area training manager. We reviewed four people's care plans, five staff files and staff training and supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staffing rotas and quality assurance records. We spoke with one professional who regularly visited the service. We contacted professionals from the local authority including commissioners and the safeguarding team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe.

Assessing risk, safety monitoring and management

- There were care plans and risk assessments in place to identify people who needed further support and help to keep them safe from harm. However, at times these lacked detail and records were incomplete.
- We reviewed care plans for three people at risk of or who had pressure sores. They had risk assessment in place for the management of pressure sores and had been seen by the Tissue Viability Nurse (TVN) who had recommended they be repositioned at certain intervals. There were some gaps in the records that we saw which meant we were not assured that they were being turned with the recommended frequency. There was insufficient documentation and gaps in the repositioning charts to verify staff were following the guidance from the TVN. Staff told us one of these people often refused to be turned which is why the repositioning charts were incomplete. However, there was no indication in their care plan with respect to any refusal or what measures were in place to mitigate against the risk of refusal.
- A fourth person had input from a dietitian following which they had recommended a food and fluid chart to be completed. Their food and fluid charts were incomplete so we could not be assured the recommendation form the dietitian was being followed.
- Two health professionals that we spoke with also raised concerns about the management of pressure sores within the service and had relayed these to the managers of the service. One professional said, "I was not happy as I discovered the wound without anyone informing me and it seems that staff are not aware about the wound."

We could not be assured that all the necessary steps were being followed to keep people safe. Care and treatment was not provided in a safe way for people using the service. The provider failed to do all that is reasonably practicable to mitigate any such risks to keep people safe from harm. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- We reviewed staff rotas which showed that staffing levels were not always consistent. We reviewed staff rotas between 24 July and 6 August 2020. During this period, we found there was no senior care worker allocated to Hazel unit during the night on three occasions, two on consecutive nights.
- The registered manager explained that a combination of COVID-19 and a voluntary suspension on new admissions to the home had resulted in low occupancy levels. As a result of this, staffing levels had been amended and reduced accordingly. A dependency tool was being used to work out safe staffing levels. According to the dependency tool, there was no nurse allocated to Hazel unit during the day and night and this unit was being staffed with one senior care worker and one care worker.
- The registered manager said there was one nurse and one care worker allocated to Rose unit during the

night. We reviewed staff rotas between 24 July and 6 August 2020. During this period, we found there was no nurse on Rose unit during the night on four occasions, three on consecutive nights. We were also contacted by a whistleblower prior to the inspection who said there was only one nurse covering all three units on the night of 20 June 2020. The registered manager confirmed this was the case but said a senior care worker was administering medicines on that date. However, staffing was still in line with the dependency tool on these days.

● Feedback from both people and staff was mixed when we asked them about staffing levels within the service.

● Prior to the inspection, we received a number of whistleblowing concerns in relation to the availability of nurses across the three units in the home. During the inspection, seven staff members told us there were not enough staff on duty to meet people's needs in their opinion. A sample of comments included, "We always have enough carers on the two ground floor units (Willow and Hazel) but having just the one nurse covering both in my opinion is dangerous. Sometimes we can cope and sometimes we can't" and "I know the home is only half full, but I just don't like the idea of having the nurses floating between different units ." Two staff members said there were enough staff, "Yes, I think the home is a well-staffed" and "There are generally enough staff."

● Three people told us that the service needed more staff whilst four other people felt there were enough on duty. Comments included, "Sometimes you have to wait if they are short", "Sometimes enough, sometimes short" and "There always seems to be lots of staff about and they usually come as quick as they can when I call them." A relative remarked, "There seems to be enough staff about today. My [family member] is very happy with the staff."

● Our observations during the inspection was that staff responded promptly to people's requests for assistance. For example, we saw staff supporting people to have a drink or get up from a chair as soon as a request for assistance was made. Staff responded promptly on two separate occasions to a call bell being activated.

● The provider operated safe staff recruitment procedures that enabled them to check the suitability and fitness of all new employees. This included looking at people's proof of identity, right to work in the UK, employment history, references and criminal records (Disclosure and Barring Service) checks. The DBS check provides information on people's background, including any convictions, to help providers make safer recruitment decisions. Records showed that agency nursing staff completed an induction to the service before working there.

Learning lessons when things go wrong

● Incidents were reported on an online reporting tool called Datix. There was one incident that CQC were notified about but was not recorded on the Datix. The registered manager explained staff on the units completed incident forms for him to upload onto Datix. He told us that not all the unit managers or nurses knew how to upload directly into Datix and acknowledged this would be a more efficient way of completing incident reports to ensure none would get missed. The managers

●The provider responded immediately during and after the inspection. They told us that the plan moving forward would be to train and empower staff to upload onto Datix directly. After the inspection we received confirmation that Datix training had been booked for staff. We will follow this up at the next planned inspection of the service.

● There was evidence that where recommendations had been made, the provider acted to ensure these were followed up. For example, following some concerns regarding unexplained bruising on a resident one of the recommendations following a safeguarding enquiry was for refresher training to be delivered to staff. We checked training records which confirmed this had been done.

Systems and processes to safeguard people from the risk of abuse

● People using the service said they felt safe living at Collingwood Court Care Home. Comments included, "Yes I feel safe", "They treat me very well. You can't fault them" and "I feel safe. They talk to me nicely. Most are very good."
● Staff were provided with appropriate training in safeguarding adults and were aware of their responsibilities. Staff demonstrated a good understanding of how to recognise abuse and protect people from the risk of abuse.
● Records that we reviewed showed that although the provider engaged with the safeguarding process, completing enquiry reports and investigating safeguarding concerns, statutory notifications were not always submitted to the CQC. We have reported on this under the 'is the service well-led?' section of the report.

Using medicines safely
● People received their medicines safely and generally as prescribed.
● Appropriate management systems were in place to ensure medicines were managed safely. Medicines were kept securely in locked trolleys and administered by trained staff who had received the relevant training and who underwent annual assessments of their competency.
● Medicine Administration Records (MAR) contained sufficient information such as photographs and allergies of each person to ensure safe administration of their medicines. MAR sheets were completed accurately and stocks tallied with the balances recorded. There were checks of medicines and audits to identify any concerns and address any shortfalls.
● Staff followed the guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines.

Preventing and controlling infection
● There were systems to assess and respond to risks regarding infection prevention and control, including those associated with COVID-19.
● People using the service said that the home was kept clean and hygienic. This view was echoed by staff who said that the home was always clean.
● Staff confirmed that they had been well supported during the pandemic with adequate supplies of Personal Protective Equipment (PPE) and hand sanitisers. Hand sanitation dispensers were available throughout the home and that staff wore PPE consistently.
● A quarterly infection control audit was completed by the registered manager. The most recent one completed in June 2020 was scored at 98%. The one action following this audit was recorded so it could be followed up at the next planned audit. A weekly COVID-19 infection prevention and control check was completed and signed off by the registered manager. The registered manager informed us the home had been COVID-19 free for seven weeks at the time of the inspection.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection we found persons employed by the service provider did not always receive appropriate training and supervision as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 18. However, we found some concerns in relation to staffing levels at night. We have reported on this under the 'Is the service safe?' section of the report.

● The provider had followed their action plan and ensured staff had received up to date dementia awareness, Mental Capacity Act and DoLS, and pressure sore/wound prevention and management training. Staff demonstrated a good understanding of their roles and responsibilities in these areas described above.
● A relative told us, "I've been incredibly impressed with the support my [family member] receives from the staff here who are all so knowledgeable and skilled at what they do."
● Staff spoke positively about the training they received and felt it was always relevant to their role. One staff said, "Yes, the training is great. Plenty of opportunities to upgrade and refresh your knowledge and skills either online or in a practical."
● Staff had completed up to date training in most areas and had the right mix of knowledge, skills and experience required to meet people's needs. Records showed staffs infection control, fire safety, moving and handling, safeguarding, and medicines management (nurses) were complete and up to date. However, 38% of staff were overdue refresher training in safeguarding adults.
● The provider responded immediately during and after the inspection. We discussed this with the managers who were aware of this gap in training and told us they had an action plan already agreed to resolve this matter in the next three months. We will follow this up at the next planned inspection of the service.

● Records showed most staff had received a formal individual supervision meeting with their line manager in February 2020, but approximately half had received a second supervision meeting in the proceeding five months. Most staff we spoke with said they did not feel supported by the services management. One

member of staff told us, "I can't recall the last time I had a supervision meeting with my line manager. they're not that regular here." The provider's staff supervision policy stated all staff should receive a minimum four individual or group supervision meetings with their line manager and fellow peers annually.

● We discussed this with managers who confirmed it had been the providers policy to temporary suspended formal staff supervisions during the COVID-19 outbreak and that plans were now in place for formal staff supervision to commence in earnest starting from August 2020. We will follow this up at the next planned inspection of the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People that we spoke with did not raise any concerns regarding access to healthcare services.

● One staff said, "We work with other professionals and organisations so that residents here receive the best care, and we try our best to follow all instructions."

● We saw evidence in care plans that other health professionals were involved in supporting people using the service. For example, we saw input from dietician, Tissue Viability Nurse (TVN), Speech and Language Therapist (SALT) and other district nursing teams in care notes. We saw evidence that health professionals had visited the home and we spoke with a health professional who was at the home on the day of the inspection.

● Some health professionals had raised concerns with us during and after the inspection about the poor communication from the home and the lack of information, especially in relation to pressure sores. The provider had taken these concerns on board and had arranged a multidisciplinary team meetings with the TVN and GP and the CCG to see how they could work more closely in future to ensure people received good care, especially in relation to the management of pressure sores. This included increased frequency of visits by the TVN and having a named nurse available to go around the unit when professionals visited to discuss care and amend care plans accordingly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's physical, mental and social needs were assessed on a monthly basis. These included nationally recognised tools to assess needs such as waterlow (to assess the risk of developing pressure sores), falls risk, nutritional and mental capacity assessments. The abbey pain scale was used to assess how much pain that people who were not able to verbalise were in.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We received information from the local authority safeguarding team prior to the inspection about the safeguarding concerns that had been raised between January 2020 and July 2020. There had been 11 concerns raised. We went through these with the registered manager and regional support manager on the day of the inspection. Out of these, the registered manager failed to submit a statutory notification for at least five. He explained that on occasion these had been missed or wrongly assumed the responsibility to submit notifications lay with other agencies. We explained this was the responsibility of the registered manager or provider. None of these had progressed to full safeguarding investigations, however the CQC require notifications for any allegation of abuse.

The registered person failed to notify the Commission without delay of abuse or allegation of abuse in relation to service users which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● There had been some disruption to the management of the service in the months leading up to the inspection. At the time of the inspection, there was no clinical services manager (CSM) in post, they had recently left the service. Prior to this, both the registered manager and the CSM had been away from the service for a period of time. Since January 2020, five nurses had left the service, some had resigned whilst others had failed their probationary period. Although access to the home was severely restricted during this period, support was provided to the managers of the service through weekly Quality Improvement Plan calls with a regional director and a member of the Operational Quality and Risk team. These calls included a review of the incidents occurring and trends identified . The registered manager said he felt supported during this period, despite higher than usual pressure on the service.

● A regional quality manager, responsible for the clinical oversight was allocated to the service whilst the CSM post was being advertised.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Morale within the service was not good and the culture was not open.

● Comments we received from staff was extremely mixed. Some felt they were neither respected nor valued. They also said the support from managers was inconsistent. Five staff said they did not always know who to approach, the registered manager or the resident experience manager and this was confusing for them. Four staff said they did not feel consulted or listened to by their line managers or the organisation. Two staff said they felt bullied.
● A sample of the comments we received included, "The managers don't listen to the carers. Management continue to do what they want to do and rarely consult us about anything", "We need a lot more support than we're getting from our managers" and "I've never known the service to be so bad as it is now. Staff morale is through the floor." Some of the more positive comments from staff were, "I can approach them" and, "I can speak to them anytime."
● Some staff said would speak up however they would be careful about what they said. Prior to the inspection, a number of whistleblowers had contacted both the CQC and the local authority. The mangers of the service told us a high number of whistle-blowers had also contacted BUPA's internal confidential channel called 'Speak Up'. One the common themes was in relation to the management of the service.
● We discussed the above concerns with both the registered manager and the regional director. They both acknowledged the morale within the service needed to be improved. A regional director said, "If anyone is using 'speak up' or contacting CQC or LA to vent or discuss concerns there must be something that is not right. We need to get under the skin of the concerns and what the issues are." They told us they were planning on holding some listening sessions and drop-in clinics to be facilitated by an independent HR employee. We saw confirmed dates had been pencilled in for these sessions. A newly appointed regional support manager had also been assigned to the service to review and investigate why staff members were feeling undervalued and unsupported.
● People using the service and a visiting relative spoke positively about the managers. Feedback included, "The manager [registered] is very impressive and always seems to make the right decisions. I am very happy with the way the care home is managed" and "I like all the managers and staff who work here. I think they're [managers] are easy to talk too."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection we recommended the provider reviewed its procedures for obtaining and acting on feedback from people and their relatives. We were not able to follow this up as during the COVID-19 outbreak there was a restriction on visitors to the home which meant resident and relatives meetings had not taken place.

● The registered manager had sent a number of letters to relatives during lockdown restrictions keeping them updated with the situation within the home whilst they were not able to visit. During this time, people using the service and their relatives were supported to stay in touch through telephone and video calls. One-off visits were also facilitated for people who were poorly or on end of life care.
● Although staff meetings had been held in March 2020 and July 2020 where staff were updated about the home, staff reported they were not always consulted or had their views heard. One of their main areas of concern included last minute changes to the rota or the need for some to ring a manager when they got to work in order to receive their work allocation for the day. Two staff told us that had to do this on the day of our visit. The registered manager and the regional director acknowledged there was some dissatisfaction with the allocation of the rotas but said this was often unavoidable and due to last minute sickness or staff absence. However, they said this aspect would be explored further during the upcoming listening sessions and they would attempt to try and work out a better way to engage with staff about their concerns.
● The managers acknowledged the difficult operating circumstances during the COVID-19 outbreak which

they felt had a large effect on morale, staffing and overall wellbeing. During this time, the company had offered 'Health Minds Support' for all staff to be able to call if they felt the need to discuss further. n COVID-19 Emergency Fund had also been offered to staff who had suffered financial hardship during the outbreak, with the company paying out close to £22,000 to 70% of staff. Reflection meetings had also been held to explore the impact of COVID-19 within the home.

Continuous learning and improving care

● During the COVID-19 outbreak, the service was running an 'operations essentials lite' system. This meant that some aspects of the quality assurance checks had been suspended during this period to focus on increasing checks and audits relating to infection control and the management of people with suspected or confirmed COVID-19.

● The provider carried out monthly quality checks which covered four main themes, the quality of care, quality of people, quality of service and quality of life and was used to identify any trends over a year using data extracted from the Datix system and other reporting tools. Regional managers had access to this reporting audit for scrutiny.

● Although care plan audits had been taking place, they did not identify the issues we found with the care plans and the risk assessments. One care plan in which the turning charts were incomplete had been audited and signed off as being acceptable. We raised this with the regional quality manager during the inspection, she told us there were plans in place to address the gaps found and she was planning on redoing al the care plan audits. The regional director told us that part of the responsibilities of the regional quality manager moving forward was to review all the care plans and the wound management within the home. We will follow this up at the next planned inspection of the service.

Working in partnership with others

● Feedback from healthcare professionals was that the service was not always collaborative and cooperative with external stakeholders and other services. However, attempts had been made to try and improve this aspect of the service by the new regional managers who were supporting the service at the time of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did notify the Commission of some incidents whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1) (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that is reasonably practicable to mitigate any such risks to keep people safe from harm. Regulation 12 (1) (2) (b).