Bupa Care Homes (CFChomes) Limited

Cold Springs Park Residential Home

Inspection report

Cold Springs Park
Penrith
Cumbria
CA11 8EY

Date of inspection visit:
27 January 2016

Date of publication:
30 March 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced focussed inspection on 27 January 2016 to check that improvements had been made following our previous inspection in September 2015. During that 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.

Following the comprehensive inspection in September 2015 the provider wrote to us to say what actions they would complete in order to meet the legal requirements in relation to the breaches. They sent us an action plan setting out what they would do to improve the service to meet the requirements in relation to the breaches and identified a date by when this would be completed.

During this inspection in January 2016 we found continuing breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found two new breaches one in Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and in Regulation 18 Notifications of other incidents of the Care Quality Commissions (Registrations) Regulations 2009.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will

seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

Concerns found during the inspection about the safety and wellbeing of some people in the home led the inspectors to share information with the local authority and the service's commissioners.

Medications and the management of them had not always been completed in a safe manner. As we found in the last inspection the records for the management of prescribed creams in the home were still not always accurate.

The registered manager and registered provider had systems in place to monitor the safety and quality of the service but these had not always been effective in identifying areas of concerns.

When accidents and incidents had occurred these had not always been reported by the registered manager to the appropriate authorities. Incidents requiring notifications to be made to CQC had not always been done.

We found that there were a number of un witnessed falls at the home which had resulted in people being injured. We saw that trends in falls had been identified at the end of December 2015 and as a result night time hourly checks for some people had been implemented in January 2016.

We saw improvements had been made in the records for the assessments of risks that had been completed and where changes in the management of risks had occurred this had been accurately recorded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The management of medications and their administrations were not consistently safe.

Risks associated with people falling had been identified and actions taken to try to prevent further reoccurrences.

Is the service well-led?

Inadequate

The service was not always well-led.

The registered manager or provider had not always notified the CQC or appropriate authorities when accidents and incidents had occurred.

System in place to monitor the quality and safety of the service were not always effectively applied in the home by the registered manager and quality 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 focussed inspection on 27 January 2016. The inspection was unannounced. The inspection was carried out by a lead adult social care inspector and a pharmacy inspector.

Before the inspection we reviewed the information we held about the service. This included information of concern collated from a significant high number of safeguarding alerts relating to the management of medications. We had also been provided with some key information about how the service planned to improve following the inspection in September 2015. We had also received regular information since the last inspection via the local authority quality improvement process for providers.

During the inspection we spoke with the registered manager, deputy manager, unit managers and four staff members, including the activities coordinators. We also spoke with people who used the service and two relatives. We looked at the care and medications records for a total of 15 people living at Cold Springs Park.

We also looked at records relating to how accidents and incidents were managed and how the registered manager and registered provider checked the safety and quality of the service provided.

Inadequate

Is the service safe?

Our findings

We looked at some people's care records in detail for the management of their medications and found three types of medicines prescribed for three people were not available for administration. We saw that the arrangements in place for ordering and obtaining people's prescribed medicines were failing. The failure of this system meant that not all medications prescribed were available to administer at the times they should have been. This meant there was a risk of people coming to harm when not having their medications as prescribed.

We saw that where there had been an error in the administration of a medication the error had remained undetected for a number of days. We saw that eye drops for one person, with a short shelf life once opened, was still in use after the date recommended by the manufacturer. This meant that staff could not be sure this medicine was safe to administer. We also saw that where someone had strong pain relief this had not been administered in the correct time as prescribed.

Since the last inspection in September 2015 we had been notified about a significant number of incidents relating to the management of peoples medications in the home. These had been appropriately reported and investigated by the local safeguarding adult social care team. As part of the actions taken to prevent further incidents all staff responsible for the administrations of medications underwent retraining.

At the last inspection we found records for the administration of prescribed creams were not consistently recorded and for some the instructions for how the creams should be applied had not been accurate. At this inspection we still saw that records for the application of creams and ointments by care staff were not fully completed. That meant it was not always possible to confirm that they had been offered to people, or applied as prescribed.

This was a breach of Regulation 12 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 saw a senior carer giving people their medicines. They followed safe practices and treated people respectfully. We were told that one person looked after some of their medication themselves. For this person we saw that assessments were completed so that the provider could ensure that the individual knew when and how to use their medication and could use it safely.

Appropriate arrangements were in place in relation to the recording of oral medicines. There was a process in place for monitoring these records regularly to check that they were completed properly.

We looked at the current medicines administration record (MAR) for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's MAR sheet. Care staff were able to check the correct dose to give. Staff had recorded that this

medicine had been given correctly.

Medicines were kept securely in locked cupboards. Records were kept of room temperature and fridge temperature to ensure they were safely kept.

The care records we looked at identified hazards to individuals' safety and we saw that these had been assessed accurately and measures recorded or put in place to reduce or manage the risks identified. For example where people had fallen frequently their care records had been reviewed to reflect any changes that may be required to prevent further falls. Where trends or themes of falls had been identified for some people we saw that a night time hourly check had recently been implemented. We could not see at the time of the inspection whether this action had been effective in reducing the number of falls.

People who used the service and the relatives we spoke with said they felt that there was sufficient staff to provide the support people needed. However one person did tell us that they felt staff spent a lot of time completing paperwork rather than spending time with people living in the home. We saw that some new staff had been employed since the last inspection and that recruitment of staff was on going.

Inadequate

Is the service well-led?

Our findings

At the last inspection in September 2015 we found although the registered manager and registered provider had systems in place to monitor the safety and quality of the service they were not always effective in bringing about improvements or protecting people from potential harm.
Following the last inspection the registered provider and acting manager provided a service improvement plan telling us about the actions they had taken to improve the safety and quality of the home.

The registered provider and registered manager used a range of systems to monitor the safety and quality of the service. We saw that some audits completed specifically on records of medications had been effective in identifying issues and actions that had been taken to correct them. However other quality monitoring audits completed had not picked up all of the issues we identified during the inspection.

We saw that the monthly home review quality monitoring visit in January 2016, completed by the provider's quality manager had not identified the concerns we found relating to the safety and quality of the service. The quality monitoring visit failed to identify the concerns relating to the safe management of medications. Nor had the monitoring process identified where incidents had occurred in the home that these had not been notified to the appropriate authorities.

This was a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (regulated activities) regulations 2014 as not all the quality monitoring systems were effective.

Where there had been a high number of falls noted with some occurring through the night this had been recognised and increased night time checks for some people at risk had been implemented. These checks had recently been implemented and at the time of the inspection we could not see how effective the checks had been in the reduction of the risks.

We found six of the incidents that had occurred since our last inspection in September 2015 requiring statutory notifications to be made to CQC had not been notified. A statutory notification is information about important events which the provider is required to send to us by law. These were mainly un witnessed falls at the home which had resulted in people being injured and requiring further medical or emergency treatment.

This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

Both the provider's quality manager and registered manager failed to recognise, even when using the established monitoring systems, where people's safety and quality of the service had been compromised. Following the last inspection the provider submitted to us a service improvement plan with actions identified. One of the expected outcomes noted in the service improvement plan was that the home's quality monitoring processes would be robust and drive improvements in the service. However in this

inspection we did not see that when the quality manager or registered manager had used these established processes that the outcomes had been achieved.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (regulated activities) regulations 2014 as the competencies of the senior managers failed to identify concerns relating to the safety and quality of the service and this raised concerns about the senior staff competencies to carry out these tasks pertaining to their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents six other incident notifications had not been submitted as required by the regulation

The enforcement action we took:

Issue a Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management and administration of medications were not always safe.

The enforcement action we took:

Issue a warning notice

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 used effectively to ensure compliance with the requirements of the regulations

The enforcement action we took:

Issue a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The competencies of senior staff did not always identify concerns relating to the safety and quality of the service.

The enforcement action we took:

Issue a warning Notice