Bupa Care Homes (CFChomes) Limited

Cold Springs Park Care Home

Inspection report

Cold Springs Park
Penrith
Cumbria
CA11 8EY

Tel: 01768890360

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12 May 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced focused inspection on 12 May 2016 to check if that improvements had been made following our previous focused inspection in January 2016. During the inspection in January we found continuing 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. We also found breaches of Regulation 18 Staffing relating to the competencies and skills of staff.

Following the focused inspection in January 2016 we issued three Warning Notices. A Warning Notice tells a registered provider or a registered manager that they are not complying with a regulation. We undertook this focused inspection to check that the registered provider had complied with the requirements of these Warning Notices.

This report only covers our findings in relation to those requirements. You can read the full report from our last comprehensive inspection, by selecting the 'all reports' link for (Cold Springs Park Care Home) on our website at www.cqc.org.uk.

Cold Springs Park Care Home (Cold Springs Park) is located in the town of Penrith and is owned by BUPA. The home provides residential care for up to 60 elderly people and is divided into two units, Cold Springs unit and Spring Lakes unit. Spring Lakes unit supports people living with dementia.

At the time of this inspection the service did not have a registered manager. 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.

There was a new manager in post who had been appointed at the home following our last inspection in January 2016. At the time of this inspection of the service the new manager had already commenced an application to become a "registered manager''.

During this inspection we found that the registered provider had met the requirements of the warning notices in relation to the previous concerns we found in January about the safe management of medications in Regulation 12 Safe care and treatment and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However during this inspection we found new concerns relating to breaches of other Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection visit we wrote to the provider about some of the concerns we had found to ask for further information and for them to provide reassurances on the immediate actions they would take. This was to prevent any repetition of the concerns we had found and to mitigate any risks associated with them.

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

The overall rating for this provider remains 'Inadequate'. This means that it was been placed into 'Special Measures' by CQC following the inspection in January 2016. 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. Another inspection will be conducted within six months from the last inspection in January, 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 this inspection on 12 May 2016 were about the assessments and plans of care about people and not being person centred in identifying specific risks or individual needs. We saw that where some people lacked capacity to make certain decisions and the need for consent was required it was not always obtained from the appropriate person. We also found that where risks relating to weight loss had been identified we could not see that appropriate actions had always been taken to address them.

We saw significant improvements had been made in the management and records relating to medications. All staff that had responsibility for managing medications had undergone training and new competency checks.

The new manager and registered provider had improved systems in place to monitor the safety and quality of the service. These had been effective in identifying areas of concerns and actions still to be taken in continuing to improve the service.

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?

Requires Improvement

The service was not always safe.

Not all risks associated with people's individual needs and care had been appropriately recognised or managed.

Prescribed medicines were stored, administered and disposed of safely in line with current and relevant regulations and guidance.

Is the service effective?

Inadequate

The service was not always effective

People's individual needs had not always been assessed or correctly identified prior to their admission to the home.

Consent and best interest decisions were not always done in line with the Mental Capacity Act 2005.

Management of weight loss was not always clearly documented

Assessed specific needs of people were not always fulfilled.

Is the service well-led?

Inadequate

The service was not always well-led.

A new manager had been appointed following our last inspection of the service. However, the new manager was not yet registered with CQC at the time of the inspection.

We found that the provider had made improvements to the ways in which the quality and safety of the service was monitored.

We found that some gaps remained, particularly around people's care planning and assessments. The provider had a service improvement plan and timescale in place to help ensure this work would be completed by the next inspection.

Cold Springs Park Care 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 was an unannounced focussed inspection on 12 May 2016 to check whether improvements had been made following our previous focussed inspection in January 2016.

Following the inspection in January we found continuing 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. We also found breaches of Regulation 18 Staffing. Because the registered provider was not complying with those regulations we issued three Warning Notices.

We undertook this focused inspection to check that the registered provider had complied with the requirements of these Warning Notices. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the registered provider's service improvement plan, the action plan for previous requirement notices and information shared by the local authority quality manager and commissioners. We also looked at the information we held from notifications sent to us about incidents affecting the service and people living there.

During the inspection we spoke with the area manager for Bupa care services, the new manager, deputy manager, unit managers, four staff members, three people who lived at the home and visiting relatives. We looked at records relating to medications for five people, records of accidents and incidents in the home and care records for seven people and in detail for two people where significant safeguarding concerns had been raised.

Requires Improvement

Is the service safe?

Our findings

During this inspection we checked whether the provider was now compliant with the requirements of the Warning Notice that had been issued following the last inspection for a breach in Regulation 12 Safe care and treatment because the management of medications was not safe.

People who used the service and the relatives we spoke with said they felt safe and that they were happy with the newly appointed manager. One person told us, ''She's (new manager) always around I can speak with her whenever I want and about anything.'' A member of staff we spoke with told us they felt the new recording system of topical medications was much easier to follow.

We looked at some people's care records in detail for the management of their medications and found significant improvements had been made to medication practices. There had been a considerable reduction in medication errors since the last inspection. New audit and checking procedures had been implemented and these showed on a daily basis stock balances and this had prevented anyone's medication from being out of stock. There was a new system in place for the recording of topical medications and again this was easy to monitor in ensuring people received the right medication at the right time.

All staff responsible for the administration of medications had received further training and a system for establishing and checking their competencies had been established by the new manager. The new manager told us she was now confident in the practises in the home relating to the safe management of medications. We were told, ''A lot of work has taken place to make sure everyone is now competent.''

We saw a unit manager giving people their medicines. They followed safe practices and treated people respectfully. Medicines were kept securely in locked cupboards. Records were kept of room temperature and fridge temperature to ensure they were safely kept.

Since the last inspection in January we had received an increase in the number of statutory notifications relating to incidents that had occurred in the home. These incidents were predominately about keeping people safe from their own behaviours. We saw that each time an incident had occurred the relevant authorities and professionals had been informed. We also saw that the new manager and staff had implemented actions to reduce risks where feasibly possible. The home was collectively working with other agencies to ensure the care and level of support required could be met by the staff in the home. On the day of this inspection the registered provider decided to increase the level of staff support available to ensure individual's needs were met and potentially reduce further risks.

We noted from one person's pre admission assessment and care records that their individual risks that might associated with their care and support needs had not been fully recorded. We have considered the impact of this on the individual and service provision later in this report under the domain of effective.

Inadequate

Is the service effective?

Our findings

During this inspection we checked whether compliance had been met with the Warning Notices that had been issued following the last inspection. We also found new concerns relating to the assessments and plans of care about people and those not being person centred in identifying specific risks or individual needs.

We saw an assessment to ascertain that the home could meet people's needs had not been not completed until six weeks after someone had been admitted to the home. This assessment identified specific behaviour management strategies and the care records included this as a daily need. However we did not see that in practise this was completed as identified. We also saw that another person who was admitted to the home in March 2016 did not have their care records completed in detail following admission as per the homes policies and procedures. Specific needs had not been assessed, risk assessed or identified within the plans for providing care and support. This meant we could not see that all of this persons individual care needs had been fully met.

We saw that the use of a sensor mat to alert staff to a person's movements was in use however the assessments for their mobility and associated risks identified did not show that the use of the mat was actually necessary. We also noted that when someone presented with changing moods and behaviours this was not identified during the review of care recorded following these incidents. This meant that the care records did not accurately reflect the level of support individual people required.

This was a breach of Regulation 9(1)(a)(b) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to providing care that is appropriate and meets people's needs. You can see what action we told the provider to take at the back of the full version of this report.

We saw from the records we looked at that where some people lacked capacity to make certain decisions and the need for consent was required it was not always obtained from the appropriate person. For one person it had been recorded that instructions relating to a request for a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) had been taken from a relative who did not have the legal authority to make such a request. This meant that people's rights were not always protected as outlined in the Mental Capacity Act 2005 (MCA).

This was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment must only be provided with the consent of the relevant person.

Where risks relating to weight loss had been identified we could not see that appropriate actions had always been taken to address them. Records we viewed showed one person had a significant weight loss within a short period of time. We did not see there were any specific management plans in place to manage the risks of continuing weight loss. Generally records we looked at for recording the food and fluid intake of people were poorly and inaccurately maintained.

This was a breach of Regulation 14 Meeting nutritional needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no evidence of suitable strategies in place to address the nutritional needs of some people.

Inadequate

Is the service well-led?

Our findings

At the last comprehensive 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. During the last inspection in January 2016 we found continuing concerns about the leadership and management of the home. Since that inspection the registered provider had taken action to address the concerns and appointed another manager from one of their other homes.

The home had continued to have support from the provider's senior management team to support the manager in delivering the company's service improvement plan that what was put in place following our last inspection. We found that various internal quality and safety audits had been undertaken to help make improvements at the home. The providers quality manager had visited monthly to carry out quality assurance checks and information from these visits had been included in action plans to help drive the improvement process.

During this inspection visit of 12 May 2016 we found that the provider had made improvements in the areas of safe and well led in order to meet the requirements of the warning notices we issued following the inspection in January 2106. However we also found new concerns identifying that there were some areas where further work was needed to ensure the safety and quality of the service provision. Specifically where we found some records relating to care and treatment were not up to date, robust or accurate.

We saw from the records of the quality manager home visit for 24 February 2016 an audit carried out had identified issues with care plans. Actions were identified to include a review of the use of food and fluid diaries as they should be for clinical reasons and not routinely used. One person's care plan needed re writing as it made reference to 'no swallowing problems' but this person used a prescribed thickener which would indicate there was a problem. It also identified areas of assessments and care plans not being completed for some people. The agreed actions points dated 24 February 2016 had not been signed off as being completed at the time of our inspection.

Another quality manager home visit for 22 and 29 March 2016 showed the care plan audits identified common areas for improvement including those that we noted during our inspection. Although the areas of concerns had been highlighted by the management audit systems the work to rectify the information had not been completed. It was also noted in the quality management audits that further staff training was required in completing the records relating to the care plans and the new manager has been tasked with this action.

Staff working at the home, people who lived at the home and their relatives all commented on how generally things had improved since the new manager had started.

The management team had in place detailed action plans to address the areas identified as requiring improvement and were working with commissioners, stakeholders and CQC to achieve and maintain the

required improvements.

We saw that the registered provider was displaying the home's current rating in the foyer. This is required by the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care This was because the plans for the care and treatment of individual people did not accurately reflect their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This was because care and treatment must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs This was because the plans for the care and treatment of individual people did not accurately reflect their needs.