CareQuality Commission

Bupa Care Homes Limited

# Cold Springs Park Care Home

## Inspection report

Cold Springs Park
Penrith
Cumbria
CA11 8EY

Tel: 01768890360

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30 August 2017

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31 October 2017

## Ratings

| Overall rating for this service | Inadequate ● |
|---|---|
| Is the service safe? | **Inadequate** ● |
| Is the service responsive? | **Inadequate** ● |
| Is the service well-led? | **Inadequate** ● |

# Summary of findings

## Overall summary

This focused inspection took place on 30 August 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Cold Springs Park Care Home provides personal care and accommodation for up to 60 people, some of whom have a dementia type illness. On the day of our inspection there were 44 people using the service.

The home had a registered manager in place. 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 manager was not on duty during out inspection. Following our visit, the provider advised us that the manager had resigned from the organisation.

We carried out an unannounced comprehensive inspection of this service on 27 June 2017. We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated the service Inadequate. After that inspection we received concerns in relation to night time staffing levels. The provider had submitted an action plan regarding staffing levels at night following our last inspection. However, this had not always been adhered to or maintained as the provider had submitted eight statutory notifications to us since our last visit reporting continuing staff shortages. A notification is information about important events which the service is required to send to the Commission by law.

As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those concerns. You can read the 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.

At this inspection, we also looked at a sample of care records, accident and incident records, and whether staff were aware of out of hours safeguarding reporting processes. We could not improve the ratings for safe, responsive or well led from the ratings they were given at our last inspection because it has only been a short time since our last visit and to do so requires consistent good practice over time. We will check the ratings of these key questions again during our next planned comprehensive inspection to the service.

At this inspection we found there were sufficient numbers of staff on duty in order to meet the needs of people who used the service.

The provider had taken seriously any risks to people and put in place actions to help prevent accidents and incidents from occurring.

Staff were aware of how to protect vulnerable adults and clear instructions were provided regarding the out of hours safeguarding reporting process.

Care records were responsive to people's changing needs. People's individual wishes, needs and choices were taken into account.

There was a positive and relaxed atmosphere in the home. Staff told us improvements had been made.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br><br>Staffing levels were sufficient to provide safe care to people who used the service.<br><br>Accidents and incidents were appropriately recorded. Risk assessments were in place and regularly reviewed.<br><br>Staff understood their responsibilities with regard to safeguarding. | **Inadequate** ● |
| **Is the service responsive?**<br><br>The care provided was person-centred.<br><br>Care records were accurate, regularly reviewed and up to date. | **Inadequate** ● |
| **Is the service well-led?**<br><br>The atmosphere at the home was calm and relaxed.<br><br>Staff were positive about recent changes at the home. | **Inadequate** ● |

Care Quality Commission

# 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. We undertook this focused inspection to check staffing levels and ensure that people were safe.

This focused inspection took place on 30 August 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. Two adult social care inspectors took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law.

During our inspection we spoke with five members of staff and observed staff supporting people with their evening routines.

We looked at the personal care or treatment records of six people who used the service, staff rotas, accident and incident records, and other records related to the operation of the service.

Inadequate

# Is the service safe?

## Our findings

At the previous inspection we identified that the provider had not ensured there were a sufficient number of staff deployed at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Staffing. We also identified a lack of robust risk assessments that impacted on the health, safety and welfare of people who used the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

The provider's action plan that they submitted to the Commission in June 2017 stated there would be a minimum of six members of staff on duty every night. During this inspection we found there were seven members of staff on duty at night for the 44 people who were using the service at the time of our inspection. We looked at staffing rotas for the previous and current week and found that apart from the two nights the provider had informed us that staffing levels were below the minimum requirement, all other shifts were covered. We looked at the staffing rota for the following week and saw all day and night shifts were planned to be covered. A staff member told us the home's permanent staff could choose to do overtime or additional shifts and wrote their names on the rota. Any remaining gaps were filled by agency staff.

We spoke with staff about staffing levels. They told us that although some agency staff were still used, staffing levels had improved and agency staff were "consistent". For example, "Things have vastly improved", "It's [staffing levels] much better" and "The rotas are being filled a bit better. It is better than it was".

We saw out of hours safeguarding information was provided for staff. This included clear instructions and contact numbers. Staff we spoke with were aware of reporting procedures and could tell us what to do if they became aware of an incident or allegation of abuse.

We looked at people's care records to see how accidents and incidents, including falls, had been managed and recorded, and whether records were reviewed and up to date. For example, one person had been found on their bedroom floor after activating the sensor mat. The person's falls history was recorded and reviewed to identify any trends. The person's GP had been contacted and social services had been made aware of the incident. The person was referred to the occupational therapist and provided with a walking aid, and their support plan had been updated to reflect this.

Risk assessments were in place for falls and moving and handling. These recorded the level of risk and actions to be taken to mitigate the risk. For example, staff were to ensure all walkways and corridors were free from obstructions, regularly check mobility aids to ensure they were in good condition, and check sensor mats were in place and working. These had been reviewed monthly and were up to date.

A 'Falls checklist" was in place for staff to follow after a fall. The checklist included guidance on the completion of accident forms, remedial action to help prevent a re-occurrence, and the contacting of families, GPs and other services as appropriate.

We looked at accident and incident records and saw these were detailed, and included actions taken to minimise the risk of a further incident. For example, one person had fallen and received a bump on the head. We saw the person's GP had been contacted to check the person over and a sensor mat was put in place to alert staff to any further falls. We checked the care plan and risk assessment for this person and found that the documents had been reviewed and updated following the accident. There was clear guidance recorded to help staff make sure this person was supported safely.

Other areas of this domain were not inspected as there had not been an increase in concerns in any of those areas.

Inadequate

# Is the service responsive?

## Our findings

At the previous inspection we identified that people did not receive care and treatment that had been personalised specifically for them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Person-centred care. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

When we arrived at the home we found most of the people living on one of the units were in bed. However, most of the people living on the other unit were still up and were walking around, watching television or having a drink or snack.

We looked at care records to see whether people's bed time preferences had been recorded. Care records included information on people's night time routines. For example, what time the person preferred to go to bed, whether they required checks during the night and evidence of choice. For example, "[Name] will go to bed when she wants" and "[Name] will say if tired and wants to go to bed."

Daily notes recorded when people went to bed and choices they had made. For example, "[Name] was sat in the lounge at the start of shift. [Name] made her own way to her room" and "At the start of shift, [name] was in the lounge. At 20:45, [name] requested to be assisted to bed."

We observed staff asked people if they were ready for bed and respected their wishes if they wanted to stay up longer. There was no pressure on people to go to bed. Staff we spoke with were knowledgeable about each person's routine. For example, we asked a staff member about one person. They told us, "[Name] normally takes herself down [to their bedroom] about 8 o'clock. She's probably watching TV." We checked and confirmed this.

Care records we reviewed were accurate and up to date, and were responsive to people's changing needs. For example, one person was found to have a blister or pressure sore on their knee. The community nursing team were contacted and their advice was recorded. A Waterlow assessment was carried out and reviewed. Waterlow is a pressure ulcer risk assessment and prevention tool. The person's daily notes recorded the use of skin care creams, regular repositioning and the use of pressure relieving equipment. A body map was completed to document where the blister or sore was located and a recent evaluation carried out showed the blister had healed.

Other areas of this domain were not inspected as there had not been an increase in concerns in any of those areas.

Inadequate

# Is the service well-led?

## Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The manager was not on duty during our inspection. Following our visit, the provider advised us that the manager had resigned from the organisation.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

When we arrived at the home we found the atmosphere was very calm and relaxed.

Staff we spoke with were positive about recent changes at the home, particularly staffing levels. They told us, "When you come in and it's fully staffed, it helps a lot" and "We've got some new starters. They've been put on the rota and when they've finished their induction that will help."

Staff also told us they no longer carried out laundry work during the night, only "normal cleaning", and with the additional staff on duty, they were able to provide better care for people.

An agency staff member told us they had worked at the home for several weeks and had initially "buddied up" with a permanent member of staff to get to know staff, people who used the service and routines. A permanent member of staff told us, "The staff get on with their job and know what to do now. There are enough of us to provide the care needed."

Other areas of this domain were not inspected as there had not been an increase in concerns in any of those areas.