Bupa Care Homes Limited

Cold Springs Park Care Home

Inspection report

Cold Springs Park
Penrith
Cumbria
CA11 8EY

Tel: 01768890360

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27 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 22 and 27 June 2017. This was the first inspection of this service following the transfer of registration from Bupa Care Homes (CFChomes) Limited to Bupa Care Homes Limited. Although the name of the legal entity has changed the person responsible for the service remains the same.

Cold Springs Park Care Home is located in the town of Penrith and is owned by BUPA. The home is registered to accommodate a maximum of 60 older people, some of whom may be living with dementia. The home is divided into two units, Cold Springs unit and Spring Lakes unit. Spring Lakes unit supports people living with dementia. At the time of our inspection there were 52 people living at the home.

The service had a registered manager. 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.

At our last inspection of the home in September 2016 we found that the service was not meeting the regulations. People did not receive care and treatment that was person centred or that reflected their needs and preferences. The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the MCA 2005 and DoLS. Quality assurance systems in place had not fully identified and addressed the impact on the wellbeing and continued safety of people who used the service. We rated the service as 'Requires Improvement'. Following this inspection we asked the provider to take action to make improvements. The provider sent us an action plan detailing the improvements they would make in order to comply with the regulations.

During this inspection we found that the provider had made improvements to help make sure people's legal and human rights were protected. However, people continued to receive care that was not centred around their needs and preferences. Quality assurance systems had not been effectively implemented and monitored to help ensure improvements were made and the wellbeing and safety of people who used the service were protected.

In addition to this we found that the service was not meeting other regulations. People did not receive safe care and treatment and were not always protected against the risks of harm or abuse. People did not always receive the support and monitoring they needed to ensure their nutritional needs were met. There was insufficient equipment to support people in a timely manner with their mobility needs. Complaints had not been responded to appropriately and the registered manager had not always told us about accidents and incidents at the home as required. Staffing levels were not always sufficient to meet the needs of the people who lived at Cold Springs Park.

The people we spoke to during our inspection were complimentary about the staff. People thought that the

care was good and that the staff worked very hard. They also said that there were not enough staff on duty to meet their needs and that they often had to wait for support. The staff we spoke to discussed their concerns about staffing levels at the home.

We found that staff had been recruited safely and that appropriate checks on their suitability had been carried out. Staff had been provided with training to help them carry out their roles. However, some gaps remained, particularly around safeguarding adults and fire evacuation procedures. Training dates had been arranged with regards fire evacuation.

We have made a recommendation that the service seeks advice and guidance with regards to the local authority out of hours safeguarding reporting process.

The sample of risk assessments and care records that we reviewed had not been kept up to date as people's needs changed. We found that medicines had not always been safely administered and managed. We received varied comments from people about the quality and standard of the food provided. We also noted that people at risk from malnutrition were not always effectively monitored and supported.

People told us and we observed that staff approached people with kindness and respect. Privacy and dignity were well maintained and protected. On the first day of our inspection there were few social or leisure activities available for people to enjoy. The activities co-ordinator was at the home on the second day of our visit and was working hard to provide stimulating activities for some of the people who used the service.

Although there was a shortage of mobility equipment we found that equipment had been maintained and kept in a clean condition. The home was generally clean and free from unpleasant odours although there were some areas in need of refurbishment.

We found that there were serious issues around communication between the staff and the managers of the service. Staff told us that they did not feel 'listened to' and some of the systems and processes in place were confusing and not utilised effectively. This had resulted in important information not being passed on or dealt with appropriately.

We found that few improvements had been made at the home since our last inspection and found further breaches of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Risk assessments had not been kept up to date or routinely reviewed following accidents and incidents. This meant that people had been placed at risk of harm or injury because information had not been updated to help mitigate such risks.

Staffing levels were inadequate. This impacted on people who used the service because their care and support needs could not be met in a timely manner.

Medicines had been stored appropriately and were administered by staff who had received training. However, gaps in recording systems meant that it was not always possible to confirm that people had received their medicines as their doctor had prescribed.

We have made a recommendation that the service seeks advice and guidance with regards to the local authority out of hours safeguarding reporting process.

Is the service effective?

Requires Improvement

The service was not effective.

People were given choices and options in order to consent to care and treatment. We found that the service acted in accordance with the Mental Capacity Act 2005.

The service could not demonstrate that people were supported appropriately and effectively with eating and drinking. Information relating to nutrition and hydration was poorly and inconsistently documented.

There was a shortage of moving and handling equipment at the home. People who used the service had to wait a significant amount of time before they received the support they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed that staff mostly approached people in a caring and kind manner.

Privacy and dignity was maintained and people were provided with explanations about their care and support.

The shortage of staff and handling equipment impacted on people receiving dignified care and having their needs met quickly.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Care needs assessments were out of date and did not reflect people's current needs. This meant that people did not receive care that was centred on their personal needs and preferences.

The lack of accurate information about people's needs impacted on the dependency tool used by the provider and therefore the staffing levels.

The service had a complaints process in place. However, complaints had not been responded to appropriately or honestly by the registered manager.

Is the service well-led?

Inadequate

The service was not well-led.

Improvement action plans had not been implemented at the home. This meant that people using the service had been placed at risk of experiencing poor outcomes.

Communication systems are not effective. Information was poorly documented and concerns were either not passed onto the managers or were ignored.

Risks were not always identified and there were no robust strategies in place to minimise risks and make sure the service ran smoothly.

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 inspection checked whether the provider was 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.

This inspection took place on the 22 and 27 June 2017 and was unannounced. This meant that the provider was unaware we were coming.

The inspection was carried out by two adult social care inspector inspectors

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. In addition we spoke with representatives from adult social care and the local safeguarding authority. We planned the inspection using this information.

We spoke with six of the people who used the service and three relatives. We also spoke with 17 members of staff including the registered manager, the regional manager, deputy manager, carers, cleaners, kitchen staff and maintenance staff.

We reviewed the care records of eight people who used the service. We looked at a sample of the policies and records that related to the service. We looked at two staff files which included supervision, appraisal and induction and examined the training record and quality monitoring documents.

We asked the registered manager to send us information relating to staff meetings, residents meetings and policies and procedures relating to keeping people safe, complaints and quality assurance reports. These documents were sent to us as requested.

We also asked the provider's Regional Director for Cumbria and Lancashire to provide us with a written plan and assurances that the home would be adequately staffed at all times in order to meet the needs and dependency levels of people using the service. This information was also provided as requested.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We spoke to people who used the service and asked if they thought there were sufficient staff within the service. One person told us; "No there is not enough staff. I need someone all the time to take me to the toilet and they don't have enough staff to do this.' Another person said; "It's not always possible to get up when I want to. They have to have two members of staff and I have to wait." We were also told; "The staff do their very best to help me under very difficult circumstances."

Health and social care professionals told us they had also been concerned with the staffing levels and lack of visible staff during some of their visits to the home.

The concerns about staffing levels and meeting people's needs were reflected in our conversations with staff. The night staff we spoke to told us that although they were busy they usually managed to complete various care tasks and meet people's needs. Although one of them felt that people did not get the care and support they deserved. One member of staff said; "There are three or four people on this unit who need to use a hoist to get up or go to bed. That needs two members of staff and each of these people take 30 to 40 minutes to help. As well as this we have to answer call bells and respond to sensor mats that may have been activated." Another member of staff explained; "We have a number of people who are at high risk of falling. We prioritise the high risks and the priority is to attend someone who may have fallen." One of the day staff told us; "The people we are looking after now are more dependent. It's 10am and there are still three people waiting to get up. They need two carers so we have to wait until someone else is free. It is very stressful and sometimes carers go home in tears." During our inspection we observed that two members of staff became visibly distressed at their situation.

We observed staff both at night and during the day. At night there should have been six staff on duty but this was not always the case. The home was sometimes staffed at night by only four members of staff. The day shift commenced at 8 am with 10 staff coming on duty. It was quickly apparent that they struggled to assist and support people throughout the morning. On one occasion three people were waiting to be assisted to get up, one of whom had to wait for an hour before staff were able to help them. The rotas we looked at confirmed that there were often shifts that were not covered. In addition there were no emergency or contingency plans in place with regards to maintaining safe and appropriate staffing levels at the home if, for example, staff were off sick. Staff told us that they "Worked as a team", covering extra shifts where possible and staying on after their shift should have finished. The registered manager confirmed that this was usually the way shifts were covered.

We noted that care staff had 'additional' duties out with their caring role. These included washing bed sheets in the laundry, delivering people's laundry to their rooms, mopping the floors, delivering meals to rooms and cleaning furniture.

We discussed our concerns with the BUPA Regional Director for Cumbria and Lancashire at the time of our inspection. They gave us their assurances that staffing levels and additional duties would be reviewed and that, with immediate effect, extra staff would be on duty during the night.

The registered manager told us that five staff were sufficient to meet people's needs at night as "People with dementia are usually very tired and go to bed after tea." The registered manager explained that two staff could work on each unit with one, "Floating" in between. We discussed with the registered manager that records for the first day of our inspection indicated that people were active at night or being assisted by the night staff to get out of bed as early as 5 am and that people often required two staff to assist them. The registered manager told us that this was the morning not night time but went on to agree that it was still the same numbers of staff on duty.

We asked the registered manager how she decided how many staff were sufficient to meet people's needs in a timely manner. She told us that she used a dependency tool. A dependency tool is an algorithm that measures people's needs and calculates how many staff are required to support them. The tool relies upon the input of accurate information and should be subject to the judgement of the registered manager. After examining the dependency tool we concluded that it was inaccurate and did not inform the rota. Furthermore we noted the dependency tool stated that less staff were required to meet people's needs than the staff that were actually on duty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing. The provider had not ensured that there were a sufficient number of staff deployed at the home. This meant that people using this service did not receive care and support when they needed it.

Medicines were stored appropriately and administered by staff who had received training to do so. There were plans in place that outlined when to administer extra, or as required, medication. There were procedures in place for the ordering and safe disposal of medicines.

We carried out checks on medicine administration record charts (MAR charts). We noted that MAR charts had been filled in correctly for the administration of oral medicines. However, MAR charts for the use and application of topical creams and lotions had not been completed. Topical creams are often prescribed to ensure that people's skin remains healthy and intact. Furthermore body maps relating to topical creams were not completed and this meant that there was no clear guidance for staff as to where topical creams should be administered. It was not possible to tell if people had received their medicines as prescribed. Failure to administer topical creams as prescribed raises the risks of people developing pressure ulcers, also known as bed sores. The National Institute for health and care excellence (NICE), Managing medicines in care homes guidance states; "Care home providers should ensure that medicines administration records including details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration).

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. People who used the service were placed at risk of harm because the systems and processes in place did not effectively promote the proper and safe management of medicines.

We reviewed a sample of people's risk assessments during our visit to the home. We found that these documents were not up to date and did not reflect the current needs of the person they related to. One person's risk assessment had been reviewed and recorded 'No change' even though it had been recorded elsewhere in their care records that their mobility levels had changed significantly.

Risk assessments had not been routinely reviewed following accidents, falls or incidents. We noted that falls diaries were not completed accurately and falls had not routinely been reported to the registered manager or, where necessary to the local authority and CQC. We found that the information recorded with regards to falls had been inaccurately recorded and poorly documented. We cross checked information between

people's risk assessments, care plans and daily notes but the records were so poorly maintained we could not be confident that appropriate action had been taken to reduce risks. The registered manager told us she was unaware of many of the falls and incidents we found in people's care records. For example one of the people whose records we reviewed had been identified at high risk of falling. There was a 'Falls Diary' in place. This record was designed to help staff identify any fall patterns as well as a record of any actions taken and the evaluation of the effectiveness (or otherwise) of such actions. There were six falls recorded in April. There were no recorded evaluations or details of subsequent actions taken following the falls in order to help mitigate risks. Further falls had been documented elsewhere in their records but not included in the falls diary. We found 15 accident reports where this person had fallen, only five of which had been recorded in the 'Falls Diary.' We found records of a further four falls in their daily notes and another recorded in the 'Professional Visits Log'.

There was also a shortage of hoists as one was out of action leaving just two available for both units. Staff told us this had been the case for some time. Records indicated that at least 10 people in the home required the use of a hoist to help them mobilise. We observed that people had to wait at least an hour, in some cases, until the hoist or sufficient numbers of staff were available. People who used the service highlighted the lack of appropriate equipment as an issue. Before we left the home, a spare hoist had been delivered to Cold Springs Park from one of the provider's other homes in the area and an additional hoist had been ordered.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. People who used this service did not receive safe care and treatment. The lack of robust risk assessments and insufficient equipment impacted on the health, safety and welfare of people using this service.

Equipment checks and servicing had been carried out. We noted equipment was clean and well looked after. Everyone needing to use a hoist had their own sling but there was also a selection of slings for emergency use, e.g. should someone need help getting up off the floor.

The staff we spoke with knew how to identify various types of abuse and were able to relate this to bullying, harassment and avoidable harm. Staff told us that they had received training that ensured they had the correct knowledge to be able to protect vulnerable people. The training records we saw confirmed this. If staff were concerned about the actions of a colleague there was a whistleblowing policy which provided clear guidance as to how to express concerns. This meant that staff could quickly and confidentially raise any issues about the practice of others if necessary.

Staff told us if they had any concerns about anyone's safety they would speak to a senior member of staff or a senior manager. However some staff were not entirely sure how to report their concerns at night or at the weekend and were unaware that the local safeguarding authority had a specific 'out of hours' contact number.

We recommend that the service seeks advice and guidance with regards to the local authority out of hours safeguarding reporting process, ensuring that this advice and guidance is passed on to all staff working at the service.

We looked at the recruitment records of four members of staff. We saw that safe systems were used when new staff were recruited. All new staff obtained a Disclosure and Barring Service disclosure to check they were not barred from working with vulnerable people. The provider had obtained evidence of their good character and conduct in previous employment.

The service was clean and housekeeping staff followed a cleaning rota. We noted that cleaning staff were continuously retrieving a hidden key for the cleaning cupboard. They told us that the previous maintenance staff had not allowed them to have their own keys. We raised this with the registered manager and the cleaning staff were provided with keys whilst we were still at the service. We saw that care staff had access to personal protective equipment such as gloves and aprons. They had completed mandatory infection control training as part of their induction and repeated this training at regular intervals.

Requires Improvement

Is the service effective?

Our findings

Health and social care professionals commented that they had developed good working relationships with staff at the home. They also said that staff were receptive to their suggestions and tried to work with them. One person thought that staff had learnt a lot from them and another told us that staff sought help and made referrals in a timely way.

All of the staff we spoke with told us that they had received induction training before working in the home. They said they worked with experienced staff to gain knowledge about how to support people before working on their own. Where people had complex needs we saw that most of the staff who supported them had received training from Bupa in how to provide their care. For example the care of people living with dementia.

We reviewed the staff training records. The records indicated that staff were mostly up to date with their mandatory training and there was a plan in place for further training. We noted that most staff had not completed their fire safety training. However, the registered manager showed us that training had been planned for early July for all staff. A further two people had been identified as becoming fire wardens and training had also been arranged for this role. The staff that we spoke to confirmed that they were provided with training to help them carry out their role.

We looked at the ways in which staff were supported and supervised in their work. The staff supervision records and supervision process was difficult and confusing to understand. We spoke to the registered manager about supervision. The registered manager made some alterations to the records and told us that staff received supervision at least six times per year. However, the records we were shown did not confirm that staff were supervised as frequently as this. We asked the provider for clearer information about the staff supervision processes, which the registered manager later sent to us.

Some of the staff that we spoke to during our inspection told us that they did not feel supported in their work. One person said; "The manager is not approachable and doesn't listen to concerns when they are raised." Another told us; "I have stopped going to staff meetings, they are a waste of time. Managers are not approachable."

We looked at some of the staff meeting minutes. The issues relating to staff shortages had been discussed and that staff didn't feel supported or were part of the team. Relatives meeting minutes continued with the same themes around staff shortages and staff skills. One person was recorded as saying; "Care staff need to be at a certain level, they need skills the job is demanding, some staff here are very good and some sadly are not."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing. Staff did not receive appropriate support, supervision and appraisal to enable them to carry out their duties effectively.

We spoke with people about the quality of the food at the service. We received varied comments. One person told us; "I think the food is excellent and we always have a choice." Whilst another person said; "The standard of food is the worst I have ever had. Hospital food is better. There is no variety."

We looked at the way in which people were supported with eating and drinking. Assessments had been carried out to establish if people were at risk of malnourishment. Where people had been identified at risk of malnutrition, dieticians had been consulted for advice. However, there was poor evidence that people were appropriately and effectively supported with eating and drinking. This was because information in food and fluid monitoring diaries was inconsistent or missing. Some of the staff told us that they had been told by the registered manager what exactly had to be recorded and how, but these instructions had not always been followed. In most cases it was difficult to tell how much people had eaten or drank over a 24 hour period. Additionally there were no indications to confirm that people had been provided with alternative options or given food and drink when they had previously refused meals or been asleep at meal times. We identified that people were losing weight throughout the service. We also noted that one person had been well supported to increase their weight and that people had been offered food and drink during the night. However, dietary support during the night was not recorded in people's food and fluid diaries. This meant that anyone assessing the person's food and fluid intake could not be certain that this information was up to date and accurate.

A member of staff that we spoke to felt that people were losing weight and becoming dehydrated, partly because of the issues around staffing levels and not having enough time to spend with people. Another member of staff told us that they had been told to get everyone in the same dining room if possible, again for monitoring and support purposes due to shortage of staff. They said that some people had complained because others; "Cough and splutter at mealtimes. It can be very off putting."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Meeting nutritional and hydration needs. People who used this service were placed at risk of poor nutrition and hydration.

The home was clean and tidy and generally well maintained. There were some areas requiring refurbishment. We were told of a heating radiator that had been leaking for some time but had not been repaired. The radiator was in a person's bedroom and leaking water raised the risks of them and staff slipping. We brought this to the attention of the maintenance staff and the radiator was fixed whilst we were still at the service.

The service provides accommodation and support to people who may be living with dementia. However, during our inspection we found little evidence of "dementia friendly" lighting, colour schemes, assistive technology or signage, including bathrooms, toilets and people's private
bedrooms. There were few aids to assist people with orientation and enable them to maintain some level of independence. We found that there was insufficient moving and handling equipment available. The registered manager was unaware that one of the hoists was out of action. In fact when we asked how many hoists were in operation the registered manager told us there were three

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Premises and equipment. The safety and independence of people using this service were compromised because of the lack of equipment and a suitably adapted environment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS applications had been made to the local DoLS Authority and were being correctly implemented and monitored.

The service acted in accordance with the Mental Capacity Act 2005. For example, if people lacked capacity staff ensured that other professionals and family members were involved in order to support people in making decisions in their best interests. These best interest decisions were clearly recorded within people's files including who had been involved and how the decisions had been made in the person's best interests. The service was aware that some family members had lasting powers of attorney. The service ensured that these were acted upon in relation to making decisions about people's care or to update family members about a person's welfare. Lasting powers of attorney give families or guardians legal rights to be involved in either financial decisions or health and welfare decisions or both. We observed that people were given choices and options in order to consent to care and treatment. Information was documented in care plans and in the samples reviewed we saw that appropriate people had been included in the decision making processes where necessary.

People we spoke with told us that they were always asked for their consent before staff supported them to do something. Staff told us that they would not provide any support without first asking for permission. Care plans in the home contained references to consent throughout.

Individuals' care records included guidance for staff about in what circumstances they should contact relevant health care services if an individual was unwell. We found evidence to show people who used the service could be confident they would be supported to access appropriate health care services, for example a visit from a GP, community nurses, dieticians and podiatrists.

Requires Improvement

Is the service caring?

Our findings

People who used this service made very positive comments about the staff supporting them. One person told us; "The staff are very nice. One member of staff in particular (name) is very kind to me. I feel well looked after and no one (staff) is ever rude or unkind to me." Another person said; They (staff) work terribly hard, they never stop. They do their best and I feel sorry for them, I really do."

Relatives spoke to also commented positively about their experience of the service. One person said; "I am very happy with the care of my relative, although they can manage to do a lot of things for themselves. Staff are very good and always let us know if there are any issues, problems or illness concerning our relative." Another relative commented; "I am pleased with the care of (name). The service has been a godsend for me. I can visit when I like and I can take my relative out if the weather is good. Staff also let me know if my relative is not well and will get the doctor if needed."

We observed that staff tried to maintain people's privacy and dignity by knocking on doors, speaking respectfully to people and making sure people were covered when being assisted with their care needs. We heard staff providing explanations to people, particularly during moving and handling procedures and this helped to relieve any anxieties people may have had. We heard staff explaining people's medicines to them and providing other explanations when visitors came into the home.

Staff spoke to us about the increased dependency of the people living at Cold Springs Park and of the impact staffing levels were having. Two members of staff told us that they used to have time to sit with people and chat or provide one to one leisure support, but this rarely happened now. Another member of staff told us; "The staff don't have time to join in with people and their activities."

We observed four people sitting in one of the lounge areas after lunch. One person was actively watching a television programme until a member of staff commenced cleaning the floor. There was no discussion about this task with the person watching the television even though the cleaning process was noisy and disrupted their viewing. There were three other members of staff in this area at the time, all were busy writing up the care notes from the morning. We did not observe any staff interaction with people during this time period.

We were told of one person receiving end of life care. An assessment had been completed and a care plan had started to be drafted. However, this person had been identified as being at risk of pressure damage. There was no risk assessment or skin care plan for this person, although we did see that this person had been kept comfortable and was regularly supported to change their position. This person was recorded as refusing food and fluids but we saw that staff had provided good oral care to help keep their mouth moist. Pressure relieving equipment had been provided by the community nursing services and was in use to help keep the person comfortable in their bed.

Although people who used the service and their visitors were complementary about the staff, people also told us of their concerns with regards staffing levels and having their needs met quickly, especially around

going to the toilet and waiting for the hoist. This had the potential to impact on people receiving dignified care.

We noted that people who used the service had been provided with opportunities to be involved with the service. Resident and relatives meetings had been held although they had not been held since March 2017. The provider told us that these types of meetings were held at quarterly intervals. We saw from the minutes of previous meetings (November 2016 and January 2017) that relatives and residents had raised concerns about the staffing levels at the home.

Inadequate

Is the service responsive?

Our findings

Care staff told us that they used to be able to support people with one to one activities or sit and have a cup of tea with them but that they no longer had the time to do this. Staff also told us that there were a number of people who were "quite active" during the night but there was no time during a night shift to try to provide suitable, stimulating activities.

The care plans that we reviewed were out of date and were not reflective of people's current needs. This meant that care and support was not always centred on individual needs and preferences. We found that care plans had not been completed accurately nor had they been routinely evaluated to help make sure the plans were appropriate and were effectively meeting people's needs. We found that where risks and concerns had been identified and recorded, these had not always been responded to appropriately and quickly. We could not be sure that people received safe care and support when they needed it.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care. People did not receive care and treatment that had been personalised specifically for them. There was little understanding of how this impacted on the health, safety and wellbeing of people using this service.

One person's care notes recorded a fall although this had not been fully and appropriately documented and reported. Their care plans had not been reviewed and updated following the accident to make sure this person's care and support needs were being safely met. There was no record of any injuries resulting from this fall until four days later even though their care notes stated that they had been supported with washing and dressing over this time period. We checked the staff handover notes and again there was no record of any injuries. The recorded injuries were significant and we could not be sure that this person had in fact received the support they needed with their personal care over the days immediately following the accident. Two weeks later this person had been identified as 'resident of the day' which included a full review of their care plans and assessments. However, the review had failed to identify the issues and gaps we found during our inspection.

Another person had requested the use of bed rails on their admission to the home, to help prevent them falling out of bed. Their care plan did not show that bed rails had been used as requested. There was no risk assessment to confirm whether bed rails were the safest and most suitable option to help keep this person safe. A day later this person fell out of bed and a sensor mat was put by their bed to alert staff that this person was moving around and might need help. However, there was no assessment to help make sure this type of equipment was the most appropriate to use nor had their care records been updated until six days after the fall. There was conflicting information and guidance for staff to follow with regards to this person's care and support. This conflicting information meant that this person was placed at risk of receiving care and support that did not meet their needs or preferences.

Information about people's care and support needs was inaccurate and this impacted on the dependency tool used by the provider and therefore the staffing levels. The registered manager was not able to

competently use the provider's dependency tool and information used to assess the number of care hours needed was not accurately recorded either in people's care plans or in the dependency tool.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. People who used this service were placed at risk of receiving unsafe care and treatment. The lack of robust risk assessments meant that the provider had not done everything reasonably practicable to mitigate risks.

People who used the service told us that there were some social and leisure activities available if they wished to join in. One person told us; "There isn't any transport from here and you can't get anywhere." They added; "Sometimes we go out for trips but they use taxis." Another person said; "I don't like to join in things much but I can do if I choose." This person told us that they liked to go to church before they moved into the home. However, they had not been told about the church service that had been held at the home on the day of our visit.

During our inspection of the home we found that there were some social and leisure activities available for people who used the service. The part time activities co-ordinator was very dedicated and had developed a weekly programme of events, trying to base these on people's interests. They ensured that the home had a reasonable link to the local community with various churches visiting each week, schools, youth organisations and wildlife trusts visiting also. The activities co-ordinator told us: "I try to take people out and 10 people went out for afternoon tea last week." They also commented on the staffing levels and that staff did not have time to join in with activities. The registered manager told us that a second activities co-ordinator had been appointed and was currently going through recruitment checks.

We reviewed the way in which the registered manager handled complaints. There was a complaints process in place at the service, which provided details of how to raise a concern or complaint and how this would be dealt with by the organisation. The policy provided information of the process expected from the person investigating the concern or complaint. This included the keeping of accurate records, investigation reports and notes. The policy stated that the provider would; 'Provide honest, evidence based explanations and give reasons for decisions.'

We found that the registered manager had received two complaints since the re-registration of the service in February 2017. The complaints were documented and had been responded to. The manager had written a letter to one person outlining the actions they had taken to address their concern in order to reduce the risks of it happening again. We asked the registered manager to show us their investigation reports. However, there were no reports and the manager had not taken the actions stated in the response to the complainant.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Receiving and acting on complaints. The complaints process was not operated in an effective and transparent manner. This meant that people raising concerns were not treated with respect and honesty.

Inadequate

Is the service well-led?

Our findings

We received varied comments about the management of the home from staff. One member of staff thought the management of the home was good, whilst others said they were reluctant to attend staff meetings because they did not feel they were listened to or that their concerns were actioned. Some of the staff that we spoke to did not have confidence in the management of the home.

Health and social care professionals commented on the management of the home. They told us that they had been working with the registered manager. People said that the registered manager had been engaging with the process and understood the need for improvement. We were told that some areas had improved but further improvements were needed and the home needed to demonstrate that improvements could be sustained.

However, health and social care professionals told us that they were not always assured by the response of the registered manager. During our inspection of the service we had similar concerns. We found that the registered manager had not always taken the actions they said they would do. This became apparent when we asked for information regarding the investigations of complaints, accidents, falls and completing notifications to CQC as required.

The care records that we reviewed provided little evidence to support that care plans, risk assessments, food and fluid diaries, falls diaries, daily notes and medication records were subjected to regular auditing and monitoring for accuracy and quality. This placed people's health and wellbeing at risk.

There were gaps in the communication processes in place at the home and important information was not acknowledged and acted upon. This was because the registered manager had not been made aware of or was ignoring significant events in the home.

We observed some attempt at the auditing process but this had not been followed with any consistency and outcomes/areas for improvement had not been achieved. For example, the registered manager had attempted to monitor the incidence of falls. The information was unreliable because staff did not always report or accurately record such events. The registered manager told us that staff did not always tell her about these events.

We reviewed the quality audit reports that had been carried out by the provider's senior managers and quality managers. We found that some of the issues identified at our visit had also been identified during internal quality audits. For example; care plans did not reflect people's current needs and identified safety risks had not been included in relevant care plans. The quality managers had identified gaps in the supplementary charts such as food and fluid diaries and the administration of creams and ointments records. There were gaps in staff supervision and appraisal meetings and staff recruitment, particularly an activities co-ordinator, was a continuous issue. We noted that despite these areas being identified improvements had not been made.

The provider uses a RAG (Red, amber, green – where green is good and red is poor) rating to help identify areas of success or where improvements are needed. The provider had carried out six monthly quality assessments and the records had shown that the service had made improvements up until the end of last year (2016). However, the latest assessment in January 2017 indicated that the rating had changed from green to amber meaning that improvements had not been sustained. Although the quality assessment had identified that quality monitoring documents had been mostly in place it also identified areas of concern related to documents and records not being up to date and lack of evidence that actions were being taken to help address the shortfalls.

The registered manager had developed a home improvement plan in January 2017. This plan should have been kept under review and updated, particularly after each monthly home review audit. However, the plan had not been updated until June 2017 where most of the issues identified were described as 'on-going' with few fixed timescales set for achieving the goals set out.

The registered manager told us that she frequently carried out spot checks and night visits to the home to help make sure the home was running smoothly at all times. The records of the visits did not support this statement and we found that the registered manager had carried out these checks in June and October 2016 and again in March 2017.

People who used the service knew who the registered manager was and spoke fondly of her. One person told us; "The manager is smashing she comes to see us every day. She talks to everyone and she knows everyone by name." However during these walk rounds the registered manager had failed to note various issues in the home such as people waiting for assistance, lack of hoists and a leaking radiator.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance. The systems to assess, monitor and improve the quality and safety of the service were ineffective. People who used this service were placed at risk of receiving unsafe and poor quality services.

Following our last inspection of Cold Springs Park the registered manager gave us an action plan, detailing how and by when improvements would be made in order to become compliant with the Regulations. During the registration process of adding this location, to Bupa Care Homes Ltd registration, the provider submitted a further action plan to address shortfalls in meeting the regulations. We found at this inspection that neither the provider nor the registered manager had made the improvements required. In addition to the continuing breaches, we found further breaches of the Regulations.

This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – General. The registered people had not ensured that they were meeting all of the required regulations, nor were they complying with the requirements of those regulations.

We checked the information we held about this service against the information we gathered at the inspection. We found evidence to support that the registered manager did not submit statutory notifications as required. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

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 8 HSCA RA Regulations 2014 General The registered people had not ensured that they were meeting all of the required regulations, nor were they complying with the requirements of those regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment that had been personalised specifically for them. There was little understanding of how this impacted on the health, safety and wellbeing of people using this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff routines and tasks took priority. There was little understanding of how this impacted on the wellbeing and needs of people using this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The lack of robust risk assessments and insufficient equipment impacted on the health, safety and welfare of people using this service. Systems and processes in place did not effectively promote the proper and safe

management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who used this service were placed at risk of poor nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The safety and independence of people using this service were compromised because of the lack of equipment and a suitably adapted environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The complaints process was not operated in an effective and transparent manner. This meant that people raising concerns were not treated with respect and honesty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems to assess, monitor and improve the quality and safety of the service were ineffective. People who used this service were placed at risk of receiving unsafe and poor quality services.

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 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were a sufficient number of staff deployed at the home. This meant that people using this service did not receive care and support when they needed it. Staff did not receive appropriate support, supervision and appraisal to enable them to carry out their duties effectively.

The enforcement action we took:

We issued a Notice of Decision to restrict new admissions to the home. Restrictions of admissions will prevent any further admissions of people whose needs are such that the staff at the home are not equipped to safely support them and keep them safe. The restriction will allow the provider time to review, assess and consider the needs of people currently using this service, review levels of staff required to meet those needs and review the way in which staff are deployed at the home.