Barchester Healthcare Homes Limited

Collingtree Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Collingtree Park is a residential care home providing accommodation and personal care for up to 79 older people, younger people and people living with dementia. At the time of inspection 70 people were being supported at the service.

People's experience of using this service and what we found
People were at potential risk from abuse due to unexplained injuries not being investigated to identify a cause. Records of injuries were not consistently completed and follow ups to injuries were not always recorded to evidence an injury was healing.

Risk assessments were not always clear regarding what actions staff should complete to reduce the known risks. Records of care tasks were not completed consistently, which put people at risk of not receiving the support they required to keep safe and healthy.

Medicine recording was not consistently completed to evidence the proper administration of medicines.

Staffing levels required improvement. People, relatives and staff all felt the staffing levels were not satisfactory. Observations completed during the inspection evidenced staffing levels were a concern.

Systems and processes to ensure oversight were not always effective. Audits had not been completed on daily recording, audits on accidents and incidents and medicines had not identified the concerns found. We found missing and conflicting information recorded about people's needs.

People were supported by staff who had received adequate training and where safely recruited. Staff were tested regularly for COVID 19 and followed government guidance of the use of personal protective equipment (PPE).

People, staff and relatives knew how to complain and felt listened to by the registered manager. Feedback was requested annually and during reviews. The provider had an action plan in place to make improvements.

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

Rating at last inspection
The last rating for this service was Good (published 14 February 2018)

Why we inspected
We received concerns in relation to staffing levels, infection control, records and care plans. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to records, risks, medicines and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Collingtree Park

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors and an Expert by Experience. The two inspectors completed the site visit and the Expert by Experience made calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return.

This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 14 relatives about their experience of the care provided. We spoke with eight members of staff including the, registered manager, regional director, care workers and kitchen staff. 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.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Unexplained injuries were not investigated. For example, we found one person had a bruise on their forehead recorded, another person had a bruise on their mouth and bruises to both arms and head recorded. However, there were no incidents or accidents recorded that may evidence the cause for these injuries and there were no investigations completed into the cause of these unexplained injuries. This put people at risk of abuse.
- Records of injuries were not sufficient to ensure follow up checks could be completed. For example, when a person had a bruise recorded there were no details of size, shape or colour. This meant staff could not be assured if an injury was healing appropriately.
- Records held conflicting information regarding a person's injuries. For example, one person's body map chart stated they had a forehead bruise and a skin tear to their left forearm. However, the handover stated bump on front of head, bruising all over right arm and legs and a skin tear on right hand.

The provider had failed to ensure systems and process were in place to investigate and immediately act upon any evidence of abuse. This is a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Risk assessments did not always contain the relevant strategies or information to mitigate risks. For example, one person did not have details regarding their diabetes and what signs staff should observe in case of a diabetic concern. People who were unable to use their call bells to summon support did not have how often a staff should check them recorded. This meant staff did not always have the information required to mitigate known risks to people.
- People were at increased risk of skin pressure damage. Repositioning records had not always been completed to evidence that repositioning tasks were carried out within the specified time frames. For example, two people's care plans stated they required repositioning every three to four hours, however records consistently evidenced gaps of five hours. Another person had a sore identified and their repositioning tasks should have been increased to one to two hours at night and three to four hours in the day. Records showed there were gaps of five hours in between repositioning tasks being completed.
- People were at increased risk of dehydration. One person's care plan stated they required hourly drinks to be offered. However, records evidence that hourly drinks were not offered. Another person's care plan stated they required a total amount of between 1.2 and 1.6 litres of fluids to be offered daily. Fluid records were not consistently tallied, and actions were not always recorded when people's fluid target was not met.
- People were at increased risk of aspiration. One person required thickener to reduce the risk of choking.

Records held conflicting information regarding how much thickener to use. For example, some fluid charts stated one scoop per drink, others stated two scoops per drink and the care plan stated one scoop. Staff did not record when or how much thickener was used.
● Medicine administration recording required improvement. People who required support with transdermal patches did not consistently have the placement of the patch recorded. A transdermal patch should not be applied to the same area to reduce the risk of skin damage. (A transdermal patch is placed on the skin to deliver regular doses of medication into the bloodstream through the skin.)

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. The provider had failed to ensure the safe administration of medicines had been completed. These are breaches of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risk assessments and strategies were in place for known risks such as falls, equipment, scalding and COVID-19.
● When a person had an 'as required' (PRN) medicine, staff had the information needed to understand when and how to administer the medicine.

Staffing and recruitment
● Staffing levels required improving. The provider used a dependency tool to identify the minimum amount of staff required on each shift. This tool evidenced the required level of staffing should be 11 staff on a morning shift, eight staff on an evening shift and five staff on a night shift. Rota evidenced these levels were not always reached. For example, on weekends they were often one or two staff short of these numbers.
● Observations identified concerns with staffing levels throughout the inspection. Lunchtime observations evidenced there were not enough staff to support the people who required help with eating and drinking in a timely manner. This left people at risk of not being able to eat sufficient amounts. We also observed that staff did not have the time to interact with people during the day.
● People, relatives and staff all told us that staffing levels were a concern. A person said, "Staff are so busy, I have to wait." A relative said, "I do think they are understaffed. I do have problems locating staff when I need to talk to them." A staff member told us, "We have no time to sit and talk to people, there are often not enough staff on shift."

We recommend the provider reviews staffing levels and the deployment of staff within the building.

● Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure staff did not have any criminal convictions and were suitable to provide support for the people living at the service.

Preventing and controlling infection
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were no records of high touch areas being cleaned throughout the day and cleaning schedules had gaps in the records. However, the home appeared clean.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Trends and patterns were reviewed monthly and lessons learnt shared with staff.

Requires Improvement

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes to ensure accidents, incidents and injuries were recorded and investigated as necessary were ineffective. For example, we found people who had a fall recorded with no injuries stated also had a body map completed with injuries logged but no cause. This put people at risk of harm.
- Systems and processes to ensure daily tasks were completed were not in place. Fluid records were not tallied daily, bowel movements and oral care tasks were not consistently recorded, repositioning tasks were not recorded regularly, and we found gaps in the recording of daily evaluations (daily evaluations are an overview of the day for a person). The registered manager did not audit these documents. This put people at risk of not receiving the care they required.
- Systems and processes to ensure safe administration of medicines were not comprehensive and did not cover the issues we found on inspection. For example, the medicines audit did not cover transdermal patches and the records for the person who did not have thickener recorded had not been audited for three months. Therefore, no actions had been identified or completed.
- Systems and processes to ensure infection, prevention and control measures were in place required improvement. We found records of high touch areas being cleaned were not in place and gaps were found in the cleaning schedules. The audit completed in September 2021 evidenced only 86% compliance. However, there were no actions recorded to rectify these issues.
- Systems and processes to identify staff deployment and staffing levels were not effective. Rotas evidenced the required number of staff were not always met. This meant people did not always receive their care as planned or have staff available to them to support food and fluids.
- Audits of care plans had not identified when information was missing. For example, one person did not have the required information regarding their diabetes.

The provider had failed to assess, monitor and mitigate risks relating to health, safety and welfare of people using the service. The provider failed to ensure accurate, complete and contemporaneous records were kept. These are breaches of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager completed spot checks randomly on staff, during days and nights to ensure staff were interacting with people in a person-centred way.

● Staff told us they felt supported by the registered manager and they worked well as a team to support people in a person-centred way.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibility under the duty of candour. However, we found no records to evidence the duty of candour had been completed as required. The registered manager told us the duty of candour had been completed but not recorded.

● People, relatives and staff knew how to complain. A relative told us, "I raised a complaint and the registered manager emailed me straight back and came up with a solution."

● Complains were recorded and responded to within the providers timeframes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their relatives were asked to feedback on the service through annual surveys and during care reviews. A relative told us, "I am asked for feedback, they are trying to make improvements." A person told us, "I am always asked if I am happy, and if anything needs changing."

● Staff were confident to raise issues or concerns and felt listened to by the registered manager. Staff told us they were able to make suggestions during meetings or they could just, "go and see the manager."

● Relatives felt involved with the service and were kept up to date on any changes or incidents involving their loved one. One relative said, "If [person] has a fall they [staff] are on the phone to me straight away. They always let us know when [person] is having a COVID or flu injections" Another relative told us, "They [staff] always let me know when [person] is struggling, then I can call [person] on the phone in the bedroom, this helps [person]."

● We saw evidence of staff and management working with health professionals and following advice. Referrals were made to speech and language therapists, occupational therapists and dieticians as needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. The provider had failed to ensure the safe administration of medicines had been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and process were in place to investigate and immediately act upon any evidence of abuse.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks relating to health, safety and welfare of people using the service. The provider failed to ensure accurate, complete and contemporaneous records were kept.

The enforcement action we took:

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