Review of compliance

Bupa Care Homes (CFC Homes) Limited The Springs Nursing and Residential Home	
Region:	West Midlands
Location address:	Spring Lane Malvern Worcestershire WR14 1AL
Type of service:	Care home service with nursing
Date of Publication:	April 2012
Overview of the service:	The Springs is located in a residential area of Malvern Link with local shops close by. It is on a bus route and there is free car parking at the front of the home. The home specialises in providing nursing care for people living with dementia.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Springs Nursing and Residential Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 26 March 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People told us that staff at the home were kind and caring. One person said "they're all really good" and "the care is very good". A relative told us that staff "nursed my mother wonderfully" and that they had "no problem with the care".

Many of the people who were living at the home were not able to express their views verbally, so we spent time sitting with them in the lounges and dining rooms, observing the daily life of the home. We saw that most people were sitting in armchairs with nothing to occupy them for long periods of time. At lunchtime, we saw that some people were not getting the support they needed.

Care plans had been reviewed and updated regularly, and we saw that when people's needs changed, this was recorded in the care plans.

We saw that the home was tidy and that the bedrooms and bathrooms were clean. In some of the lounges we saw that armchairs and sofas were stained and in poor condition. One relative told us "cleanliness is not good" and another person said that there were "never enough cleaners".

The home did not have fully effective systems in place to manage the risks associated with the management of medication.

What we found about the standards we reviewed and how well The Springs Nursing and Residential Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People were not always receiving care which met their assessed needs. Records did not always provide the information that staff needed to provide support for people.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People were not being fully protected from the risks of infection.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The home did not have fully effective systems in place to manage the risks associated with the management of medication.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that staff at the home were kind and caring. One person said "they're all really good" and "the care is very good". A relative told us that staff "nursed my mother wonderfully" and that they had "no problem with the care". We saw that staff took time to explain everything to the people they were supporting, and got down to each person's level to speak with them.

Many of the people who were living at the home were not able to express their views verbally, so we spent time sitting with them in the lounges and dining rooms, observing the daily life of the home. There were many occasions during the day when there were no staff in some of the lounges. On one occasion we heard a person calling out for several minutes. We went to the lounge and saw that there were no staff. The person was trying to get out of their wheelchair and was very distressed. We went to find a member of staff to come and reassure the person.

We saw that most people were sitting in armchairs with nothing to occupy them for long periods of time. Although there was music playing in some of the lounges, in others the television was on and there did not appear to be anyone watching it. In some of the lounges there were items for people to use such as soft toys and colouring books, but one visitor told us "there's not a great deal for them to do all day". Although there were some reminiscence and sensory items in the corridors, some of these were not in good condition.

The weather was very warm on the day of our visit, and we were concerned to see that

there was a lack of drinks available to people in most of the lounges during the day. In one lounge, the temperature of the room was 25 degrees Centigrade and only one person out of the nine people in the room had a drink. We checked the fluid recording charts for some people who had been assessed as being at risk of dehydration. The charts indicated that some people may not have been drinking enough to meet their needs. There was no evidence to show if these people had been offered drinks, and there was no evidence of action taken when the records indicated a low fluid intake. This means that staff could not be certain that people's hydration needs were being met.

Some people who live at the home had been assessed as being at risk of developing pressure area damage. Records showed that this risk had been regularly re-assessed, and that care plans were in place so that the risk was reduced as far as possible. For example, one person's care plan stated that they needed to sit on a pressure relieving cushion and that an air mattress should be on their bed at the correct pressure for their weight. We saw that the person was sitting on the correct type of cushion and that there was an air mattress on their bed which had been set at the correct pressure. This means that the home is taking appropriate action to ensure that people do not develop pressure area damage.

We saw that staff were encouraging people to take short walks around the home, and staff told us that they were aware of the health benefits of exercise for older people.

At lunchtime, we saw that some people were not getting the support they needed. In one of the dining rooms, there were five staff members who were supporting people who could not eat independently, but we saw that there were ten people who were not able to manage their meal without assistance. For example, one person who was eating with their hands tried to get up and leave the table and was gently encouraged to stay. A passing staff member put a spoon into the person's hand. The person put down the spoon and used their fingers to eat. They spat the food out onto their fingers and then put it on the table. The food fell off onto the person's lap, and a staff member picked it up and again gave the person a spoon. Therefore this person was not given the support they needed to eat their meal. In another dining room, we saw that lunch was a sociable occasion and that staff were aware of, and attentive to, people's needs. In this dining room, there were enough staff to provide the support that people needed.

When we looked at the care records for one person, we saw that the care plan stated that the person should have a thickener added to their drinks as they had been assessed as being at risk of choking. The medication records showed that the GP had prescribed thickener for this person, but there was no information about how much thickener should be added to the drinks and no record that the thickener was being used. We asked a care worker and a nurse about this, and both of them told us that the person did not have thickener added to their drinks. The nurse checked the stock of thickener and could not find any belonging to this person. This means that the person was not receiving the treatment which had been prescribed for them by their doctor.

Other evidence
Care plans had been reviewed and updated regularly, and we saw that when people's needs changed, this was recorded in the care plans. The home had care plans in place for people's short-term needs such as chest infections, so that staff would know how to provide the care and support that the people needed.

Some of the information in the records was not consistent and this could have meant that staff did not have correct information. For example, one person's care plan stated that their skin was intact but the daily records included a recent entry about a dressing to a wound. The manager assured us that this record was not correct, and that the person's skin was intact. It is important that records are kept accurately so that staff have the correct information about people's care needs.

There was evidence in the records that the home had requested medical help whenever necessary, and one relative told us "they get the doctor in if they need to and they always ring me to let me know". Records showed that the home had also requested support from other health care professionals such as dieticians. This means that staff were able to get specialist advice and support so that they could meet people's needs.

Our judgement
People were not always receiving care which met their assessed needs. Records did not always provide the information that staff needed to provide support for people.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
Although we had not planned to review the prevention and control of infection at this visit, we found issues which concerned us. In some of the lounges we saw that armchairs and sofas were stained and in poor condition. One armchair had a small amount of a brown substance stuck to it. The walls in one of the dining rooms and in some of the lounges were marked with what appeared to be dried splashes of liquid. The registered manager told us that the walls could not be wiped clean as the type of paint used could not be wiped. She said that the walls would need to be re-painted.

We saw that the home was tidy and that the bedrooms and bathrooms were clean. However, one relative told us "cleanliness is not good" and another person said that there were "never enough cleaners".

In one of the corridors there was a rummage box of sensory items for people to use. We saw that among the contents was a ball of knitting wool. The wool was coated with a brown sticky substance. The box also contained a sticky sweet wrapper. We gave these items to a member of staff to be disposed of.

On each floor of the home there was a sluice room where staff disposed of soiled waste. The doors to these sluice rooms had a key code entry pad and the registered manager told us that they were kept locked. On three occasions during the day we found that two of the sluice rooms were unlocked. This means that there was a risk that people could have entered the room where soiled waste was stored. Because many of the people who live at the home have dementia and therefore might not understand the risks associated with soiled waste, this could put them at risk of infection.

Other evidence
We did not check the home's policies and procedures for the prevention and control of infection.

Our judgement
People were not being fully protected from the risks of infection.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not speak with people using the service about how the home manages medication. Everyone who lived at the home when we visited was not able to manage their own medication, and therefore relied on the staff to do this for them.

Other evidence
We had not planned to review the management of medication at this visit, but we became aware that the rooms in which medication was being stored were very hot and that this was potentially unsafe. This is because most medications should be stored below 25 degrees Centigrade. The temperature in one of the storage rooms had been recorded as 29 degrees Centigrade. The registered manager told us that she was aware of this issue and had made the company which owns the home aware of it. She said that they were hoping to get an air-conditioning unit installed so that medication could be kept at the correct temperatures.

We saw that each person had a risk assessment to show if they were able to manage their medications themselves. Care plans included a list of each person's medication. We checked three care plans, and found that the lists were up to date and included all current medication.

Some people had been prescribed medications, such as painkillers, to be taken on an "as required" basis. There were clear records to show when these medications should be given. The Medication Administration Record (MAR) charts for three people taking

"as required" medication were fully completed with no gaps.

One person was being given their medication covertly. This means that the medication was being hidden in food or drink. There was a clear record of how the decision to do this had been made, and the record included evidence that it was in the person's best interests to be given their medication even when they did not wish to take it.

Some people had been prescribed creams or ointments. We saw that the records to show that these had been applied were complete, and provided a full record of when staff had used the creams and ointments.

One person had been prescribed a thickener for their drinks but staff were not able to find the thickener and there was some confusion about its usage. The registered manager assured us that she would check with the doctor and would ensure that there was clear information for staff about this thickener.

Our judgement
The home did not have fully effective systems in place to manage the risks associated with the management of medication.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People were not always receiving care which met their assessed needs. Records did not always provide the information that staff needed to provide support for people.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People were not always receiving care which met their assessed needs. Records did not always provide the information that staff needed to provide support for people.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People were not always receiving care which met their assessed needs. Records did not always provide the information that staff needed to provide support for people.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities)	Outcome 08: Cleanliness and infection control

	Regulations 2010	
	How the regulation is not being met: People were not being fully protected from the risks of infection.	
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: People were not being fully protected from the risks of infection.	
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: People were not being fully protected from the risks of infection.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The home did not have fully effective systems in place to manage the risks associated with the management of medication.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The home did not have fully effective systems in place to manage the risks associated with the management of medication.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated	Outcome 09: Management of medicines

	Activities) Regulations 2010	
	How the regulation is not being met: The home did not have fully effective systems in place to manage the risks associated with the management of medication.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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