Mrs W A and Mr P Marucci

Spring Cottage

Inspection report

Bazley's Lane
Langton Road, Norton
Malton
North Yorkshire
YO17 9PY

Tel: 01653695354

Date of inspection visit:
26 September 2018
28 September 2018

Date of publication:
04 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Spring Cottage is a 'care home' situated outside of Norton in a rural setting. The inspection took place on 26 and 28 September 2018. The inspection was unannounced on the first day and announced on the second day.

Spring Cottage provides residential care for to 16 older people. People live in two adapted buildings; most people live in the main home, with a separate bungalow providing accommodation for up to two people that are more independent. 13 people were living at the service during our inspection. Most people living at Spring Cottage had strong connections to the surrounding local area, having grown up and lived their working lives there.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Since our last inspection the local authority had identified some concerns with the provider following a visit from their quality assurance and contracting team. The provider was pro-actively working with the local authority and following an action plan to remedy these issues and improve their practice.

There was a registered manager in place, who was also one of the partners in the business. 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. The registered manager was supported with the day to day running of the service by a manager and a deputy manager.

At the last inspection in April 2016 the home was rated good. At this inspection we found the home required improvement. This is the first time it has been rated requires improvement.

Recruitment processes were not applied robustly to ensure all appropriate checks were completed for staff prior to them commencing work at the service. This included Disclosure and Barring Service (DBS) checks, written references and health questionnaires.

Quality and safety was not being consistently monitored by the provider. Health and safety checks were not always being completed to ensure the premises were maintained and to minimise risks to people and staff at the home. The provider took immediate action on window security based on the issues we identified.

Staff received supervisions but these did not follow a set format and the frequency of these taking place varied. Staff had completed training, many of their training certificates had expired. The provider had recently introduced a new e-learning system and was working to improve the monitoring of staff training.

Roles and responsibilities within the management team were not always clear. The registered manager was not always monitoring the home and had not identified issues we found on inspection.

A system of audits was being developed within the home. At the time of inspection medicines was the only area being audited. This meant the provider did not have a system for identifying and addressing issues within the home.

The provider had a clear value basis, with people living together in a homely environment, where they were treated with dignity and respect. The home had links to the local community.

Mealtimes were a positive experience, which people and their relatives shared with staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and systems were being updated to support this practice. Consent was sought prior to people receiving any care interventions.

Staff knew people's histories and provided personalised care. People received emotional support, which helped improve their wellbeing.

People, their relatives and staff were able to speak with managers and were involved in the running of the home. The registered manager made themselves available to people and their families.

We found the provider was in breach of three of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

Recruitment processes were not consistently followed to ensure appropriate checks had been completed prior to staff working at the home.

Health and safety checks were not completed across all aspects of the home to help monitor and maintain safety.

Staffing levels were sufficient and people received assistance in a timely way.

Is the service effective?

Requires Improvement

The service was not always effective.

Records of staff probation reviews were not always being kept to show how staff suitability was considered.

Robust plans for staff supervisions, appraisals and training were not in place to support them in their roles.

Mealtime experiences were enjoyable and people received a sufficient nutritional intake.

Is the service caring?

Good

The service was caring.

People received emotional support.

Staff understood what mattered to people and upheld their dignity.

Is the service responsive?

Good

The service was responsive.

Staff knew people's life histories and spent time reminiscing with them.

Activities were offered within the home and local community.

People and their relatives felt able to approach managers to suggest changes and improvements.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Roles and responsibilities within the management team were not always clearly defined.

Policies and procedures did not always reflect current legislation and practices within the home and were being updated.

People, their relatives and staff identified as being part of a community with shared values.

Spring Cottage

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 was planned to check whether the provider is 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 26 and 28 September 2018. The inspection was unannounced on the first day and announced on the second day. The inspection team consisted of one inspector.

Prior to inspection we reviewed information we held about the home. This included the Provider Information Return (PIR). This is information we require providers to send us at least once annually, to give some key information about the home, what the home does well and improvements they plan to make.

We reviewed statutory notifications the provider had submitted to CQC to inform of us certain events affecting the home. We contacted Healthwatch and the local authority commissioning and safeguarding teams. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to plan our inspection.

During the inspection we looked at the care files of four people and five people's medication records. We reviewed documentation and policies relating to the running of the home including staff rotas health and safety checks and the equality and diversity policy. We looked at the recruitment files of three recently recruited members of staff. We looked around the home and checked the environment.

We spoke with four people who use the home and two relatives. One professional spoke with us to tell us about their experience of working with the home. We spoke with members of the staff team including three care workers.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes were not followed to reduce the risk of unsuitable staff supporting people living in the home. Two care workers had started work without their Disclosure and Barring Service (DBS) checks having been returned to the provider. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and help reduce the risk of unsuitable people working with vulnerable groups. Recruiting staff without DBS checks went against the provider's own recruitment and induction policy.

Two members of staff had started work without their written references having been received. The manager advised they had spoken with one care worker's referee but had not documented the conversation.

The above findings were a breach of regulation 19 fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager provided copies of rotas to show one member of staff had shadowed a colleague while they awaited their DBS, reducing the associated risks. Where issues were recorded on a member of staff's DBS this had been considered and risk assessed.

Two staff had started work without health declarations in place to ensure they were able to perform tasks relevant to their role and consider any reasonable adjustments required to support this. On day two of the inspection the manager provided us with health questionnaires, which had been completed by ten members of the staff team.

Health and safety checks were not consistently completed in the home. The provider did not have a legionella risk assessment. Checks of water outlets and hot surfaces were not being completed to manage any risks associated with legionella, scalds or burns. When we checked the hot water temperature this was within an acceptable range to touch. There had been no reported illness or accidents to indicate people were at risk. One bedroom window and a number of windows in communal areas were single-glazed and had not been risk assessed. This could be unsafe in the event any pressure or force was applied to them. We discussed the issues identified with the provider, who took immediate action to address the concerns, purchasing a product to strengthen the glass. We advised the provider to follow best practice guidance from the Health and Safety Executive.

The provider had no clinical waste arrangements in place should they need to dispose of infected products. We discussed this with the manager, who made arrangements to source a clinical waste contractor to help reduce the risk of infection within the home.

Staff could correctly explain the term 'safeguarding' and described how changes in people's behaviours may be a sign of abuse. A safeguarding policy was in place. This did not refer to current legislation or local authority safeguarding protocols. The provider was in the process of updating their policies and procedures.

The provider had a whistleblowing policy, detailing how staff could raise concerns and escalate them to the local authority and/ or CQC if needed. Whistleblowing is a process for staff to anonymously inform other organisations of issues they identify with the provider.

People told us there were enough staff on shift. When they needed assistance one person said, "I've not had to wait for help." One person commented, "If there is a problem there is always someone that will come." They described how when they had experienced seizures a member of staff had remained with them. This helped the person feel reassured and safe.

The rotas showed staffing was sufficient. The provider did not use agency staff and was able to cover any absences with other members of the staff team. The registered manager provided on-call support should this be required. Team meetings showed staff were encouraged to use this. This demonstrated staffing levels were satisfactory and staff had support should they need it to maintain safety in the home.

Personal emergency evacuation plans were in place to identify the level of support people would require in the event of an emergency. Risk assessments identified risks specific to people's needs. One person had risk assessments for bruising and extensive bleeding. Another person had a choking risk assessment in place and required a soft diet to reduce this risk. This contained details of foods the person could have and level of supervision they required to maintain their safety. The staff we spoke to demonstrated they were aware of this risk.

The local authority had identified previous shortfalls with how the provider was managing medicines. Following this feedback, the provider had made improvements to medicine management arrangements. People received their medicines safely as prescribed. The temperature of the medicine room was being monitored. A list of staff signatures was in place to identify which member of staff had completed medicine records. Topical Medication Administration Records (TMARs) were used for people who required creams and other products to be applied to their skin. These included a body map to help staff identify how these medicines should be applied. One person had a medicine where the dose may change depending on monitoring by health professionals. The provider recorded their correspondence with the person's GP surgery and had established a system for communicating changes in dose.

Some people had medicines 'when required'. When required protocols recorded how people would communicate if they needed this medicine. One person used a specific word to refer to their pain relief, which staff demonstrated to us they were aware of.

Staff described how they would record any accidents or incidents and recognised some injuries may require monitoring. Staff told us they would handover this information to colleagues working on the following shift to alert them to this. Incident reports were completed following any accidents people experienced. These recorded the nature of the accident and how people were supported following this, including where medical attention had been sought and any monitoring the person required. Actions to prevent future incidents and maintain people's safety were identified. This showed the provider was monitoring accidents/ incidents and sought to improve safety in the home.

Requires Improvement

Is the service effective?

Our findings

Probation reviews were not recorded. The manager told us new staff received probation reviews six and 12 weeks into their role to check their suitability. In three staff files probation reviews were not recorded. The manager acknowledged this and advised they were reviewing their induction and probation processes.

The provider was not using a training matrix to help track staff training requirements and dates for completion and renewal. In two staff records we looked at, we found training certificates were not always up to date.

Staff received supervisions and annual appraisals but these were not robust. There was no set frequency for staff receiving supervisions and supervision records did not follow a set format. Appraisals did not include specific goals to help the professional development of staff.

The above findings were a breach of regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had plans to implement a training matrix and improve their practices for monitoring training. The provider had recently started using a new e-learning system and had identified which training staff would be expected to undertake. Staff told us this was positive and they found it quicker and enjoyed learning at their own pace.

The provider was working with the local authority to make improvements to their supervision processes.

People consistently spoke highly of staff and the effective support they received. One person told us, "If I want anything I've only got to ask, they're always very helpful." People were confident staff knew their needs and were capable of providing them with support. One person said, "Whoever chose the staff did a terrific job." Another person added to this, "The staff are fantastic, they've always been helpful, polite and attentive."

People's needs were assessed to check the home was able to provide them with the support they required.

Staff recognised the importance of continually seeking consent. We saw evidence of people having signed to consent to their care and photographs being taken. A person told us, "They always seek my permission; 'would you like to do this?'

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures call the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principals of the MCA and found they were. One person who had been assessed as not having capacity to make informed decisions, had a DoLS in place, with no conditions attached. This meant people received care and support that was legally authorised, the least restrictive option and in their best interest.

Where people had representatives legally authorised to act on their behalf for particular decisions, copies of the associated Lasting Power of Attorney (LPA) certificates were in their care file. The manager was aware of which people had LPAs.

All the people and relatives we spoke to praised the amount and quality of food provided at the home. One person said, "The food is very good, it's all freshly cooked here." Another said, "The homemade soups are wonderful, rich and nourishing." A four-weekly lunch menu was available to view.

Care plans detailed people's preferred meals. For example, one person liked their breakfast early and enjoyed porridge with some sugar, a slice of toast with marmalade followed by a cup of tea. A person told us, "If you don't like what's being cooked they'll do something else."

People were supported to enjoy their meal time experiences. We observed lunchtime at the home. When one person appeared to have difficulty using cutlery the manager offered alternative options to aid them. These suggestions were welcomed by the person. People were offered 'second helpings'. Staff ate their meals alongside people, chatting with them. The management team were clear that any friends or family visiting people should be able to eat together as they would in their own homes.

People described staff communicating with their families. A person said, "The home speaks to my family and let them know if there is ever a serious problem." Relatives confirmed the home kept in contact with them. This meant information was being communicated effectively with families.

Information was communicated within the staff team through a handover between shifts. A communication book had been used to record changes in people's needs. A care worker remarked on the effectiveness of this for staff returning from days off or from leave.

People received support to access healthcare services. Hospital passports were in development at the time of our visit. This is information about people's needs the provider can share with health professionals to inform how they provide care and treatment. One person told us, "My family are thrilled with how well and healthy I look." People told us they saw their doctor when they needed to. A record was kept of where each person had received visits from healthcare professionals and the outcome of this visit. A community nurse told us, "The staff are excellent here, I have never had any concerns here." They described any contact they had with the home as having been appropriate and any advice they gave being acted upon.

People were able to move freely around the home and garden. We saw people enjoying spending time in the privacy of their own rooms and socialising in communal lounges. People's bedrooms were personalised with ornaments, pictures and their own furniture. One person said, "I feel very comfortable in this room, it's my own." This demonstrated the home was adapted to individual needs.

Good

Is the service caring?

Our findings

People and their relatives were consistently happy with the care provided and spoke highly of it. A relative commented, "This is the next best place to home." People told us they were satisfied with how staff spoke with them. One person said, "I'm certainly looked after here, they talk to me kindly." Another person said, "They absolutely treat me with respect. Staff recognised the importance of how they spoke to and treated people. A care worker told us, "We treat people how we would treat our own mums and dads." We observed positive caring interactions between people and staff, sharing jokes together. This showed staff treated people with kindness and compassion.

People received emotional support. One person had experienced some traumatic events prior to their admission to the home. Their relative commented on how care workers took time to understand their family member and provided support under difficult circumstances. The person had responded particularly well to a care worker they had known from their local community. This relationship and sense of shared history was important to the person and helped support their emotional needs.

Staff understood people's emotional needs and provided care in a way that promoted their wellbeing. One person's support plan recorded they were anxious about appointments and this was reduced by a member of staff accompanying them. The manager explained they had also spoken to the hospital to reduce the frequency of the person attending appointments and to minimise any emotional distress.

People felt able to express their views. We observed people had regular access to the registered manager when they were providing care, which was used as an opportunity to discuss their opinions.

An equality and diversity policy was in place. This referred to information being made available in alternative formats should this be required in-line with the accessible information standard. The accessible information is a legal requirement of health and adult social care services to make sure people with a disability or sensory loss are given information in a way they can understand.

Personal records were locked away. The provider had data protection and confidentiality policies in place.

Staff knew what mattered to people and how they wanted their dignity maintained. For a person receiving end of life care, applying their make-up remained important to them and care workers described supporting the person to do this. This demonstrated people's dignity was upheld.

People were supported to be independent. Staff recognised the importance of assessing each person's situation and enabling them to be independent. Care files referred to how staff should support people to promote their independence. One person's personal hygiene care plan stated, '[Person] is able to wash their hands and face and personal areas if the carer prepared the flannel with water and shower gel.' We observed one person setting the tables at lunchtime; a task they enjoyed. The person was prompted step-by-step by the registered manager to put out serviettes and then condiments. The person told us, "I like to help out." Staff acknowledged the need to promote people's independence, balancing this against their

support needs. One care worker said, "You don't want to take their independence away or see them struggling, it's a fine line."

Good

Is the service responsive?

Our findings

Care plans were person-centred and had a section dedicated to each person's life story. This included names of people's family members and where they had grown up. Staff knew people's histories. We saw the registered manager reminiscing with a person about their former job. When we checked the person's care plan this information was recorded. This ensured people could be consistently supported and their histories could be understood by staff. The provider was updating their care files and had recently finalised a structure for this.

Support plans contained details of people's preferences and explanations as to why they may behave in particular ways. One person's care plan described how they had previously disliked having a bath and were frightened of this due to their personal history. The care plan detailed how following emotional support from care workers, they had progressed to having a bath once a week. This demonstrated care being provided in a personalised, responsive way.

Staff understood items holding significance to people. One person valued their diary, which they used to help them recall events. Care workers recognised this helped prompt the person's memory and provided them with reassurance.

Staff understood that people's support needs may vary. One person told us how they often felt very tired following a specific medical treatment they were undergoing. They described how staff would enquire how they were and empathise with them. This flexible response ensured the person was offered additional support when required.

Activities were offered in the home including church services and singers performing. One person said, "The singers are enjoyable, I love a good sing-song". During our visit, an outing to a local lavender farm was arranged. The registered manager took photos of people on the trip, which they sent to their family members to share what they had been doing. Where people declined to participate in the trip they were given options to include them in the activity in other ways, such as having a souvenir brought for them.

People could pursue their hobbies and interests. One person enjoyed gardening and had grown their own roses, which they had entered into a local agricultural show and won first prize for. This achievement was celebrated at the time and recorded in the person's care file. Another person told us they had previously enjoyed walking into the local town. This enabled them to access the local community and continue to exercise.

People told us they had a good quality of life living in the home. One person had stayed at the home for respite following illness. They said, "Since I've come here they've revived me and I'm looking forward to living again." This showed the person saw the home as enhancing their life.

People described friendships they had formed at the home. One said, "We have a laugh and take the mick out of each other." Where people were at risk of social isolation, staff described spending time with them

and trying to engage them in social activities within the home. People described staff 'popping in' to spend time with them. One person used social media to keep in keep in contact with friends and family. People could form new relationships and maintain existing connections.

People and their relatives could approach managers to provide feedback on their care. One relative described staff always recorded and acted on any requests they made, such as providing their family member with prescribed medicine if they became distressed. A person said, "I have no complaints, if anything, compliments all round." No complaints had been raised in the past year. Another person told us, "If you want a change you just say and it's acceptable." This meant the home was willing to listen and act on suggestions.

People's end of life preferences were recorded in their care plans. A community nurse commented on the additional support staff provided to those approaching the end of their life, ensuring people received regular support to keep them comfortable. One person was receiving end of life care at the time of inspection. Their relative told us, "Staff worked well with the local hospice and have taken heed of the things they've been asked to do. Staff make sure they are comfortable." A best interest decision had been taken about the person's end of life arrangements. Anticipatory medicines were in place. End of life care was referred to in the person's care plan to ensure staff were clear of the person's wishes and were able to provide them with the support they needed.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was supported by a manager and deputy manager. Roles and responsibilities within the management team were not always clearly defined. The deputy manager was completing supervisions for the manager. We spoke with both members of staff about this arrangement.

The registered manager was not always overseeing and monitoring systems and processes within the home to ensure they were being applied. The registered manager had not identified issues we found on inspection.

Many of the policies and procedures were not up to date and did not reflect practices happening in the home. For example, the safeguarding policy did not refer to current legislation. The recruitment and induction policy did not include a clear process for the probation period and how the provider would use this to assess the suitability of new staff.

There was no training matrix in place to identify staff training requirements, as a result we found examples where accredited training expiry dates had been passed. The provider had developed a medicine competency assessment for observing staff administering medicines but had yet to use this.

Staff supervision was happening infrequently and did not follow a set format to consistently support staff and monitor their practice.

Health and safety checks had not been completed across all aspects of the home by the provider to ensure it was safe. Prior to our inspection, the provider was not aware of the checks they should be undertaking.

The provider did not have an established system of audits in place or effective processes to ensure quality and safety of all aspects of the home or to drive forward any required improvements.

The above findings were a breach of regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was in the process of updating their policies and procedures to provide staff with up to date guidance when carrying out their role.

They had recently started to introduce audits. At the time of inspection, medicines storage and compliance were the only areas where formal audits had been recorded. Where actions had been identified, such as a missing patient information leaflet for medicines, this had been followed up. The manager advised they were working with the local authority to undertake audits more widely across the home. We saw evidence of audits the provider was planning on introducing, covering areas such as health and safety and dignity.

The provider had a strong family centred ethos, where people lived as part of an extended family unit. One relative had moved their family member to the home for this reason as they had come from a large family

and related to this setting. The deputy manager told us, "We want people to feel it's their home, we're passionate about it." Staff wore their own clothes to add to the welcoming, casual feel of the home. One person said, "It's like home from home." Staff identified with these values and felt that the staff team worked to these. One care worker said, "We support each other and we all feel like friends." Staff described feeling passionate about the home and wanting their relatives to live there should they require residential care.

Staff felt the management team were supportive and approachable. People and their relatives echoed these views. Many of the staff team had worked at the home for many years. One care worker told us, "We are happy here, it's the longest job I've ever had."

People and relatives engaged with the home through ongoing dialogue. A relative said, "It's an open-door policy all the time, the registered manager is open, honest and very approachable." A 'residents' questionnaire' had been completed annually to give people the opportunity to identify what the home was and was not doing. The questionnaires showed people were being supported by the home and identified positive practice.

Staff had the opportunity to be involved in the running of the home through regular contact with the management team. They told us they could approach the registered manager or manager should they have any concerns. Staff meetings were held and were used to remind staff of best practice and changes happening in the home, including updated policies. Staff meeting minutes showed they could express their views on issues affecting them such as the provider's annual leave system. This demonstrated staff could make suggestions and were included in changes to the home.

The home had links to the local community. Many people living there had lived in the local area. The home is located near to a racing paddock. The registered manager described people watching the horses training and then watching them racing on TV. This enabled people to remain connected to their local area and share in this with others living at the home.

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 17 HSCA RA Regulations 2014 Good governance (1)(2)(a)(b) The provider did not have systems in place to assess, monitor and improve the quality and safety of the service, mitigating such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed (1)(a)(c)(3)(a)(b) The provider failed to implement and operate robust recruitment procedures, including undertaking any relevant checks to ensure staff were suitable for the role before commencing independent duties.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1)(2)(a) The provider did not follow robust processes to check the suitability of staff and ensure they received appropriate supervision, appraisals and training.