Norse Care (Services) Limited

Springdale

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 July and 11 August 2017 and was unannounced.

Springdale provides residential care for up to 36 older people. At the time of this inspection there were 32 people living within the home. The accommodation is over two floors with a variety of communal areas.

There was a registered manager in post. 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.

However, at the time of the inspection they had not been at the service for three months. An acting manager was in place. This person was a registered manager of another of the provider's services. This person is referred to as the manager throughout this report.

This inspection found three breaches of the Health and Social Care Act 2008 regulations. These related to cleanliness and infection control, dignity and respect and the governance of the service.

Some people's rooms contained unclean equipment including commodes and bowls used for brushing teeth. Whilst the equipment was not being used communally, germs could still be passed indirectly from person to person by people touching unclean equipment or surfaces.

There were instances where people's dignity was not upheld. Some people had not been given any choice about whether they had male or female staff to support them.

Other than issues relating to the cleanliness of commodes the provider had not identified the concerns found at this inspection. This indicated that the quality assurances systems were not robust in this service.

There were enough staff to meet people's needs. However, there had been a high requirement for agency staff in recent months. Recruitment had taken place and the manager anticipated that the home would be fully staffed with permanent staff members in coming months. Robust recruitment processes were in place. There were well organised arrangements in place to manage people's medicines.

People were supported by staff who had received appropriate training. However, staff training for infection control was the only area that was substantially behind with significant staff numbers not having undertaken updated training in this area.

The food was appetising and people had access to snacks and drinks throughout the day. The mealtime arrangements needed better staff organisation to ensure a more positive mealtime experience for people.

We received mixed reviews from people about the staff that supported them.

People's care records contained sufficient detail to help staff provide effective support to people. However, aspects of care for two of the four people whose care records we reviewed had not been appropriately planned for or followed up.

The service had seen a lot of changes in staff over the previous six months. Some people felt that the service had deteriorated. However, others felt that improvements were beginning to be made in the home.

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 consistently safe.

Improvements were required to ensure that equipment was clean and that routine practices in the home did not present risks of the spread of infection by cross contamination.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding adults' procedures.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

The service worked in accordance with the principles of the Mental Capacity Act 2005.

People were supported by staff that were trained and staff felt supported by service managers.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some practices we observed did not uphold people's dignity.

We observed both good and poor interactions between staff and people living in the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Plans were not always in place to ensure that changes to people's needs were implemented promptly.

People knew how to make a complaint and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance systems in place had not identified the areas of concern we found during this inspection.

The service had experienced significant changes in management and staff over the last six months. However, a new permanent manager had been recruited and was due to commence duties soon.

Springdale

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 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 31 July and 11 August 2017 and was unannounced. One inspector and an expert by experience carried out the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by one inspector.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us over the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority for their views on the service.

During our inspection we spoke with five people who used the service and five visiting relatives. We also spoke with the acting manager, two deputy managers and three care staff members. We viewed the care records for four people and the medicines records for four people. We also looked at records in relation to the management of the home. These included the recruitment files for three staff members, staff training records, compliments and complaints, quality monitoring audits and minutes from meetings held.

Requires Improvement

Is the service safe?

Our findings

This inspection identified concerns relating to the cleanliness of equipment used by people and practices which put people at risk of the spread of infection by cross contamination. We found that most commodes contained seamed cushioning which had meant that dirt and debris had collected in the seams which were difficult to clean. Another commode had a soiled back and seat cushion. We observed that commode lids were not always put back on top of the commode bowl after use. Sometimes we saw that they were on the floor. On one occasion the unclean lid had been placed on a person's bed.

Bowls used by people to empty their mouth into when they brushed their teeth had multiple areas of dried toothpaste on them. Whilst these bowls were not being used communally, germs could still be passed indirectly from person to person by people touching unclean equipment or surfaces.

One person ate their meals at a small table in their room. We observed that a used continence pad in a plastic bag had been left on this table. The table was sticky and a towel spotted with jam from the person's breakfast was still being used by them at lunch. In another room we found an unclean toilet roll on a table where the person kept their snacks.

We saw from the service's staff training matrix that training in infection control had expired for 20 staff members a year ago. The provider had failed to ensure that staff received the requisite training to enable them to identify and take appropriate actions relating to cleanliness and infection control.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware that the commodes were old and told us that they had requested replacements which had been agreed.

On the first day of our inspection we found pipework at shin level in a communal toilet that became very hot when the hot water tap was run. This presented a risk of burns to people. We brought this to the attention of the manager. This pipe had been lagged by the second day of this inspection.

Risks to people's wellbeing were identified and suitable actions taken to reduce risks as far as was possible. We found that risk assessments were up to date and covered a wide variety of areas such as pressure care, nutrition and falls. These provided suitable guidance to assist staff to support people safely.

People told us that they felt safe living in the home. One person said, "I have had other people come in to my room at night. But I know I can my lock my door if I want to." Another person told us, "Before I lived here I was falling over sometimes but since I've been here I haven't had a fall." A third person told us, "When I have a bath staff help me. They never leave me alone."

Staff we spoke with had received training in safeguarding matters and understood what issues would

constitute a safeguarding concern and what action would need to be taken.

Prior to our inspection we had received periodic concerns about a high reliance upon agency staff who did not always know people well enough to be able to meet their needs effectively. This had caused extra work for other staff on duty, had put them under considerable pressure at times and had not always resulted in positive experiences for people in the home.

During this inspection people living in the home, their relatives and staff all told us that this had been the case for several months, but the situation had improved in recent weeks. The manager told us that agency staff not turning up when expected had sometimes caused staffing shortages in recent months. In the four week period prior to this inspection records showed that the service had required between seven to 17 of 63 shifts a week to be filled by agency staff. However, a recruitment drive had meant that some new staff had commenced work and the manager expected to be fully staffed with permanent staff members by the end of September 2017.

Most people felt that there were enough staff to assist then when necessary during the day. However, two people told us that they sometimes had to wait longer at night. One person told us, "Often if I need help at night they're busy helping someone else. A lot of the people here need two carers, so I don't think two on duty is enough." Rotas showed that two staff were on duty overnight. Staff told us that they were able to meet the staffing numbers deemed necessary by the provider's staffing calculation tool, but one staff member felt that on occasions they could do with an extra staff member in the mornings.

The provider had a robust recruitment system in place to reduce the risks of employing unsuitable staff as far as was possible. This system included checks on staff supplied by agencies.

We looked at the arrangements in place to manage and administer people's medicines. One person told us, "Staff give me my pills and watch me take them. Usually they're at about the same time each day."

One person's care records showed that they had been prescribed a short course of vitamins with the recommendation that this was to be continued with over the counter supplements when the prescribed course finished. The person had two days supply left of the prescribed vitamins. We could not determine that arrangements had been made for when the prescription ran out and raised this with the manager. They assured us that they would action this.

Medicines were stored securely and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled medicines. These require extra precautions and special storage arrangements because of their potential for misuse. Access to them was restricted and the keys held securely. We carried out a random check of the medication arrangements and found that accurate records were kept for medicines given to people and that these corresponded with the stock levels of medicines that were held. Guidance was in place for staff about when it was safe to administer medicines prescribed for use 'as required.'

Good

Is the service effective?

Our findings

The provider had specific areas of training that staff were required to complete and we were provided with the service's training matrix. This showed that a high proportion of staff had completed up to date training in all mandatory areas other than infection control.

We spoke with a newly recruited staff member who had no previous experience in care. They told us about their induction programme and the training they had received. They explained how they had spent up to two weeks shadowing experienced staff members and had undergone competency testing before they were able to support people on their own. They told us that they felt confident as a result of their induction. All the staff we spoke with told us that there was a supervision and appraisal system in place and that they received a good standard of support from the service managers.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found that it was.

Staff told us that people living in the home were able to make their own decisions on day to day matters and that some people might require some assistance on occasions with this. Staff knew when it was appropriate to make minor decisions for people which were in the person's best interests and when it would be more appropriate for a formal decision making process to be held. Applications had been made to the local authority to restrict some people's freedoms in order to help keep them safe. The provider had acted in accordance with relevant legal requirements.

Most people were positive about the food and drink options available. We observed the lunchtime meal on both days of our inspection. The food looked and smelled appetising and people were offered choices. However, we saw that one table of people had finished their main meal before they were offered a drink. One person's relative arrived part way through lunch and they supplied the people on their family member's table with drinks. Some people had already started eating their meals before they were provided with a plate guard to stop their food from being pushed off of their plate. One person who went on to drop food down their clothing had not been offered a clothes protector. Some people needed occasional assistance to eat. Staff assisted people for a short period of time and then left them. Sometimes they or another staff member returned to assist further. People clearly enjoyed the food they were offered, but their experiences would have been more positive if the lunch time period had been more organised.

People were supported to access a wide range of health care professionals as required. We saw that appropriate referrals were made so that people received support from health specialists, for example the falls team, as well as from other professionals such as GPs and community nurses. However, the service had not sought the guidance of health care professionals to support them in responding to one person's refusal to receive foot care.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people living in the home and their relatives about the staff. We observed some good interactions from staff when assisting people, but we also observed some less positive interactions too. We also found that people's dignity was not always promoted.

One person told us, "Staff can be a little sharp at times, but not unkind." Another person told how they had spent a day in bed as they hadn't felt well. Whilst they didn't feel like they needed to see a doctor, they felt that staff should have asked if they wished to see one. A relative told us about a complaint they had made on behalf of their family member. A staff member had been rude to them. They told us that an apology had been received, but that the staff member concerned now avoided their family member.

Some people told us that they were not asked whether they were happy to be supported by staff of either gender. One person said, "I would prefer female carers but know that's not always possible. There's male staff here, but I'm used to it now." One relative told us that a male staff member washed their family member who was female, but their family member had not been asked whether this was okay.

During lunch we observed a staff member had been supporting one person to eat, but then went off to assist someone else. When they returned the person was dropping jelly on to their lap. The staff member rolled their eyes and walked off without offering assistance, before returning again at which point they assisted the person to eat a little more. This did not demonstrate a positive attitude towards the person being supported.

On the first floor we observed one person sat in their room eating their lunch at a small table in their underwear. Their door was open and they were in clear view of anyone in the corridor. A short time afterwards we saw that the person, still in their underwear, had walked the length of the building. A staff member arrived and began to escort the person back to their room. However, the staff member had left before they reached the person's room as we saw the person enter their room alone. Thirty minutes later the person was still in their underwear in their room and visible from the corridor through their open door.

We saw a pair of knickers and a used continence pad on the floor in one person's room. The used but wrapped continence pad we saw on one person's table which they used to eat on had been left for approximately three hours but the breakfast dishes had been cleared away in the meantime.

These concerns and the infection control issues previously referred to were not indicative of a service that consistently upheld people's dignity. Consequently, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "They're very caring here. I think of this as my home now, not just my room." One relative told us, "The staff here are brilliant, they are kind and helpful." We reviewed complimentary letters the service had received. One stated, "The staff work tirelessly to make residents safe and secure. The food is fantastic. Ten out of ten." A letter from another person's relative indicated how well their family member

said they were looked after and that they were very content living in the home.

We observed mainly positive and friendly interactions between staff and people in the home. Appropriate and warm physical contact was made by staff when people were upset or to acknowledge them. Staff got down to people's own level so they didn't tower over people when they were sitting down. We saw that most staff had a good rapport with the people they supported and there was laughter and a relaxed atmosphere in the home.

We saw that staff offered to help people move to a quieter area when noisy maintenance work was being carried out. Staff made sure that people were comfortably seated to eat their meals and provided extra cushions or helped them re-adjust their positing as necessary.

Requires Improvement

Is the service responsive?

Our findings

We found that care plans were reviewed and updated regularly. We saw that people's views and those of their relatives where appropriate had been sought and were reflected in people's care records.

Most people's records contained information about their life histories, interests, hobbies, and contact details of people who were important to them. These gave a clear picture of who the person was and how they wished to live their life.

Assessments and care plans were generally of a good standard and person centred. For example, we noted very specific information and guidance for staff about how to support one person with complex needs in relation to their mobility and how to use specific equipment to assist them.

However, we found that where referrals had been made to health professionals it wasn't always clear that appropriate follow on actions had been taken.

One person had recently been visited by the falls team and a chart of exercises that had been recommended had been placed in their room and in their care records. However, there was no record to show whether staff had been supporting the person with these exercises. We raised this during the first day of our inspection and we saw on the second day of this inspection that the person was receiving the necessary support.

For a second person, no arrangements had been made to ensure that they continued to receive vitamins as recommended by their GP.

We saw that one person had very long toenails and was barefoot on both days of our inspection. They would not have been able to wear any hosiery or footwear. Staff told us that the person was living with a mental health condition and often declined assistance with personal care. We observed them exhibiting behaviours that put them at risk of self-neglect or accidental harm. They required a high level of support. The person preferred to stay in their room which was some distance from the main areas of the home and staff were often not present in this area. We were concerned about the service's suitability to meet the complex needs of this person. The manager told us that they would request support from the local authority and request a review of the person's care arrangements.

A programme of activities was in place for most afternoons. A member of staff who had completed a morning shift was allocated to support people with activities for two hours after lunch. We observed staff asking and encouraging people to join in activities happening in the activities room. A staff member told us, "If people don't want to do what is planned we will try and do something else." One person told us, "There are things to do here like bowling, which I enjoy and jigsaw puzzles."

We found that there was little for people to do in the mornings and several were sitting in various parts of the home with nothing to occupy themselves with. Some enjoyed sitting in the foyer watching people come and go which gave them opportunities to chat with people. We saw from minutes of meetings that people

were asked for their ideas about how they would like to spend their time. Several people indicated that they would like some trips out. However, one person told us, "There aren't any trips out now. I'm sure there used to be, but not recently."

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People and relatives told us that they would be willing to speak up if necessary. There was evidence in the records we looked at that showed the manager had dealt with complaints promptly and to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The provider had an auditing system in place to help identify any concerns to manage the quality of the service that people received. Regular audits were completed on various aspects of the service and included medicines management, care plans and health and safety. These audits identified where action was required and we saw that appropriate actions were in hand.

The infection control audit was done on a quarterly basis and had last been completed in July 2017. This had identified three rooms where the commodes had needed a more thorough cleaning. The manager had subsequently met with domestic staff later that month to discuss the audit. Domestic staff had felt that their workload was unrealistic and ways address this had been discussed. We also had identified concerns relating to commodes. We were advised that new commodes were to be purchased.

The arrangements in place to monitor the service were not effective and had not identified the infection control and dignity concerns we found or the inconsistent support people received at lunchtimes. The manager told us that they and the deputy managers conducted a daily 'walk around'. However, the oversight of the day to day operating of the service was not identifying where improvements were needed. For example, it had not been identified that yellow plastic boards warning that floors had been cleaned had been left blocking people's access to toilets for two hours after the floors had dried. One person who did not require the use of a pressure cushion had one in their room. This had not been identified which meant that equipment was not appropriately managed, and someone who did need a pressure cushion might not have one available to them.

Consequently, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not been working at the service since March 2017. Since then a registered manager from another of the provider's services had also been managing Springdale with the support of two deputy managers. This change, in combination with less than adequate staffing arrangements at times, had not resulted in a stable service over the last six months. One person told us unhappily, "It's changed, but I'm not prepared to say any more." Another person said, "It has changed here quite a lot. It used to be like a five star hotel, but I would recommend it up to a point."

We were advised that a permanent manager had been appointed and they were due to commence duties in the next few weeks.

There was a pleasant atmosphere in the home. We heard lots of laughter and cheerful chatter throughout both days of our inspection. The views of people living in the home and staff were sought on a regular basis through general conversations and meetings. Any suggestions made for improvements were considered and implemented when appropriate. A survey completed in 2016 by people living in the home showed that at the time they were generally satisfied with the care and support they received.

Staff told us that they received a good level of support from the management team, that they were open to suggestions and took appropriate actions if they raised any concerns. One of them told us, "They really listen to us here. Things have improved since the acting manager took over. The reliance on agency staff is getting better and we're getting some new permanent staff here that are working out well."

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not always ensured that service users were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection control concerns meant that people were not protected against the risk of the spread of infection by cross contamination. Regulation 12 (1) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that quality assurance systems effectively identified areas requiring improvement in the service. Regulation 17 (1)