Four Seasons (DFK) Limited

# Springfields Care Home

**Inspection report**

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## Ratings

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| Overall rating for this service | Requires Improvement |
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

This inspection took place on 4 and 5 November 2014 and was unannounced. Springfields Care Home provides nursing and personal care for up to 85 older people who may also be living with dementia. Care is provided in four units – Willow, Sycamore, Maple and Elburton. At the time of our inspection there were 64 people living in the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our inspection in March 2014 we told the provider to take action to ensure that people's care and treatment was planned and delivered in a safe way. We also asked the provider to take action to make improvements in relation to consent to care and treatment, record keeping and quality monitoring. We carried out an inspection on 12 May 2014 and found improvements had been made in relation to the planning and delivery of people's care and treatment. The registered manager had provided us with an action plan and we reviewed this and the remaining issues during this inspection. We found these had been addressed.

# Summary of findings

There was not enough staff to meet people's needs safely in three of the units – Maple, Willow and Sycamore. Staff were being taken from Elburton to support people in the other units, for example by taking the tea and coffees round on the first day we were at the home. Staff were trained however the registered manager advised this required updating. People gave us a mixed picture of whether they felt staff were trained to meet their needs. Most people felt staff were trained well.

On Maple, there was only one hoist available for people which meant they had to wait for staff to meet their care needs. The registered manager agreed to address the issue with the hoist on Maple to ensure there was adequate equipment across the home to meet people's needs.

The majority of staff were following infection control procedures. However, staff on Maple were not which placed people at risk of cross contamination. The registered manager addressed this at the staff handover to ensure this was no longer the case. They stated they would monitor this to ensure infection control practices were safe across the home.

Staff interacted kindly with people, but some people experienced less positive interactions as some staff did not always act in a manner which was caring. Staff were focused on care tasks and did not always have time to spend with people. Relatives, and some people, raised concerns about the lack of things to do to pass the time. In Willow, Maple and Sycamore, where people relied on staff to do this with them, people were not always being kept active or stimulated in a way to ensure they maintained their interests.

People were having their nutritional needs met however dining was not a positive experience for everyone. Staff on two of the units were using techniques to support people that were not appropriate. For example, by feeding two people at once or not using a napkin to wipe spilled food from people's faces. The registered manager and areas manager agreed to address this. They advised it was not how staff were advised to support people eat their food.

The training and supervision of staff was not robust enough to ensure all staff were able to meet people's individual needs. The registered manager identified this was an area which required more attention. They agreed to review this to ensure this was improved.

People's care plans were difficult to read and follow and lacked detail about the person to ensure they received care in the way they desired. People were not always involved in planning their care and treatment or having this recorded to ensure continuity of care. For example, staff told us they relied on staff handovers to keep them up to date on people's needs and there were times they did not write down or pass on information to colleagues.

Best interest decisions were being made for people who lacked capacity to consent to their care and treatment. However, general statements were made about what people could or not consent to. This meant staff did not always have the information available to ensure people were being supported to maintain their right to make decisions about their care.

Springfields had a local and national management system in place. Some of the concerns we observed during this inspection were highlighted in quality audits dated January 2014 which were sent to head office. However, these were not always acted on. Both locally and nationally it was not clear when responsibility for tasks was delegated this was followed up. The registered manager and area manager agreed to review this and advised us Four Seasons had recently been restructured to address the same concerns. They showed us a clearer line of accountability was now in place but it was too early to assess how successful this had been.

There was a complaints policy which was followed by staff to ensure individual complaints were recognised however, people told us they were not always resolved to their satisfaction. Complaints were not being used to ensure positive change to the service for everyone.

People told us they were happy and felt safe at Springfields Care Home. Relatives and health professionals linked to the service gave a positive picture about the service and how people's needs were being met. The registered manager and deputy manager were mentioned favourably by all we spoke with.

# Summary of findings

Staff were recruited safely and received training in safeguarding adults. Staff understood how to keep people safe. Staff were knowledgeable about the care people required.

People had the risks associated with their individual needs assessed and reviewed regularly to keep them safe. People's medicines were administered safely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

# Summary of findings

## 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. There were not enough staff to meet people's care needs. People and visitors on Maple were not protected by staff following correct infection control policies. The registered manager addressed this at the next staff handover and put plans in place to monitor this.

People's risk assessments were regularly reviewed to ensure staff knew how to meet people's needs in a safe way. Medicines were managed safely by staff.

People felt safe. Staff were knowledgeable about how to identify abuse and keep people safe. Staff were recruited safely.

**Is the service effective?**

Requires Improvement

The service was not always effective. Staff were trained however, the registered manager advised this required updating. People gave us a mixed picture of whether they felt staff were trained to meet their needs. Most people felt staff were trained well.

People's consent was being requested but it was not always recorded. Applications to ensure people were not being deprived of their liberty illegally were in progress.

People were having their nutritional needs met however the dining experience was not a positive experience for everyone. People had their health needs met.

**Is the service caring?**

Requires Improvement

The service was not always caring. Staff were observed speaking to people kindly. However, all staff did not treat people with kindness and respect. Some staff spoke about people rather than to or with them. People's dignity were respected during the delivery of personal care.

People were not always consulted about their care and treatment. However, staff demonstrated they understood people well.

People felt they were well cared for in the home. Relatives were positive of the care their family member received and felt they were always welcomed.

**Is the service responsive?**

Requires Improvement

The service was not always responsive. People did not receive continuity and consistency of care because care plans did not reflect people's personal requirements and records were not kept up to date.

Activities were provided however there were times when people did not have anyone supporting them. Visitors felt activity at the weekends would enhance their relative's lives.

# Summary of findings

There was a complaints policy. Complaints were not always resolved to everyone's satisfaction. The service did not demonstrate that complaints improved the service or prevented the concern being repeated

**Is the service well-led?**

The service was not always well-led. A new structure had been brought in by the provider as they had recognised there were issues in how their homes were manager. At Springfields there was not always a clear line of accountability for delegated responsibility. The area manager and registered manager stated this was under review and they would look at how this could be improved.

Quality audits were completed however action was not always taken to improve the service when concerns were raised by this process.

People and staff felt the service was well-led but raised concerns about the leadership of the provider organisation.

**Requires Improvement**

# Springfields Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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.

The inspection took place on the 4 and 5 November 2014 and was unannounced.

Three inspectors and an expert by experience completed 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.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also reviewed information we had received from health and social care professionals with knowledge of the service and people who had raised concerns about the service. 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 spoke with 25 people who lived at the service, 11 relatives and visitors, one health professional, 15 staff members, the registered manager and the provider's regional manager. We looked around the service and observed how staff related to people they were caring for. We reviewed 10 records related to people's care and health needs. We looked at nine staff files and training records. Other records held by the service such as how they measured the quality of care, audits, complaints, and policies and procedures were also reviewed.

Requires Improvement

# Is the service safe?

## Our findings

There were insufficient staff to ensure people's needs were met safely. Prior to the inspection we received information which raised concerns about the staffing levels within the service.

On Maple, one visitor said: "They all do their best, but they are understaffed." They told us their relative had been kept waiting for the toilet because there were not enough staff to assist and the person confirmed this had caused a problem for them. Another visitor said: "There are some staff shortages, especially at weekends."

One person said "It takes ages to get to the toilet. I ring and I have to wait." Another person told us they were sometimes reluctant to get out of bed as they were afraid staff would not be available to get them back into bed promptly when they became uncomfortable in their chair. They said "It's okay most of the time but there are pressure points, such as when food is being distributed."

A third person said they could not discuss any concerns or worries with staff because "The staff are too busy to tell. I could speak to the boss [the registered manager]." They also said: "If you're off colour the staff are very good. But you're the last in the queue," and "I struggle to get anything done" with regard to getting timely support. They explained they had to wait for help, such as to go to the toilet or have a bath. They said "They mostly turn up but sometimes they go astray." We also met people who had not been helped up in the morning as early as they would like. The staff said this was because they had to prioritise people and looked after "the frail, more dependent people first" which meant others had to wait.

We observed people on Maple, Sycamore and Willow had to wait significant amounts of time to have their care needs met. People on Willow and Sycamore who were living with dementia had varying ability to ask for support. They relied on staff to recognise their needs. Staff on Willow confirmed there were not enough staff on duty to spend time with people to ensure other needs were not missed. On Sycamore, staff encouraged people to sit down if they got up to move around. Staff said this was to prevent falls.

The registered person had not ensured there were always sufficient numbers of staff employed. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and the staffing rotas confirmed there was always a nurse on duty on Maple and Willow. The registered manager told us they assessed people's dependency needs to ensure they had enough staff to deliver care safely. We were told they would review the needs and look at times in the day when more staff may be required to meet people's needs.

A staff member told us agency staff were used if there were absences due to sickness. Sometimes it was not possible to fill the post if they were told too late, but staff felt this was not the management's fault.

Staff did not always use good infection control practices. Prior to the inspection, we were told there were concerns about infection control practices on Maple. There was a slight odour of urine on Maple. We observed on Maple that staff took bags for laundry and bags for used continence products from room to room. These were place on the carpeted floor instead of the frames provided. This meant any soiled items could leak on to the floor. This posed a potential risk to people, staff and visitors. We told the registered manager who stated action would be taken at the next handover sessions to ensure this practice was corrected.

Staff in the laundry were not provided with, or using, aprons and gloves. This may lead to cross contamination issues as staff from the laundry regularly went into other areas of the service in the same uniform. The registered manager agreed to ensure laundry staff were provided with aprons and gloves to reduce the likelihood of infection and cross contamination within the home.

Apart from these two examples, staff demonstrated a good working knowledge of infection control. There were hand gel and paper towels in place for staff, people and visitors to wash their hands. Clinical waste was disposed of safely and collected by a contractor at regular intervals.

People's medicines were managed, stored and administered safely. Individualised guidance was available to staff on the use of these medicines, to ensure people received consistent personalised care in relation to their medicine needs. Where medicines were given without people's knowledge or consent, two people's records

Requires Improvement

# Is the service safe?

required updating to reflect this. One person's record noted a verbal communication from the doctor saying medicines could be given covertly, but this had not been confirmed in writing. We spoke with the registered manager who advised these records would be updated to ensure they were accurate.

People were protected by staff that were knowledgeable in recognising abuse and how to keep people safe from harm. People told us they felt safe living at Springfields and that their possessions were also safe. Relatives expressed the same positive opinion. One person told us they felt "very safe living here. They look after us and make sure that nothing happens to us".

Staff undertook training in safeguarding adults and understood what constituted poor practice. They said that if they had concerns about people they would immediately report their concerns to either a senior carer or the registered manager. They felt they would be listened to and any concerns addressed.

Risk assessments were undertaken for people and reviewed regularly. These included Waterlow (skin care to prevent pressure areas), manual handling, falls and nutritional needs. Risk assessments were linked to care planning. For example, a new care plan for moving and handling had been completed for one person where a falls risk assessment identified an increased risk. Risk assessments were in place for individuals who could not use a call bell and details about how often staff should check to see if they required any support and were safe.

Safe recruitment practices were in place and appropriate checks were undertaken before new staff began working in the home.

The fire service told us they visited the premises in April 2014 and were happy with the home's fire evacuation system at the time.

Requires Improvement

# Is the service effective?

## Our findings

Staff were trained however the registered manager advised this required updating. People gave us a mixed picture of whether they felt staff were trained to meet their needs. Most people felt staff were trained well. However, one person felt this could be improved and one relative said: "They're learning on the job" with the example given that one staff member had not known how to use the equipment required to supporting their relative. The registered manager advised training in respect of specific service user needs such as diabetes, mental health, epilepsy Parkinson's, catheter care and peg feeding took place but were not recorded. The registered manager was unable therefore to tell us if any staff had not received this training or required updating to ensure they were practice to current expected practice. The activity coordinators had not received training to ensure they understood the needs of people living with dementia. In discussion, they felt training in this and people's other needs would enable them to better support and interact with people living with dementia. Staff who administered medicine were having their competency assessed. Qualified staff had their competency to carry out their role checked.

Five staff had received an annual appraisal (designated by the provider policy as due January-December 2014). Records showed all staff had not undertaken regular supervision to review their practice and any development needs. One staff member said they did not have feedback about how well they were carrying out their role unless a relative raised concerns. Two other staff members said they did have supervision meetings when they had received positive feedback about their development and could also speak with the registered manager or deputy manager at any time. They also told us the nursing staff monitored and corrected staff practice if necessary.

People, when appropriate, were assessed in line with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were also knowledgeable about how the principles of the MCA applied to their practice. The MCA provides the legal framework to assess people's capacity to make specific decisions. The DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. However, the capacity assessments did not concentrate on specific situations the person could or not consent to. For example, in records staff noted on the 23 October 2014 for one person it stated: "Can make everyday choices about activities of daily life" rather than specific issue decisions in line with the MCA. This meant people may not be having their rights in this areas respected. Best interest decisions were clearly recorded and involved people's social workers, GPs, family and their power of attorney (POA) as appropriate.

The registered manager said they had made three applications to the local authority to legally deprive people of their liberty as they considered this was in their best interests. They told us other applications were pending. In the meantime, staff were seeking to ensure they were using the least restrictive measure to ensure people's freedom of movement and welfare were not unduly restricted.

People's formal consent to their care and treatment was not always clearly recorded on their care records. People who could give their consent told us staff always asked and waited to ensure they were agreeable to care being given. Staff asked people if they wanted to get up for the day and if they wanted their medicines. One visitor said: "staff respected [my relative's] decision when the person declined a flu vaccine once". Some people were noted in records as having declined to sign their care plan. The registered manager told us the provider was looking at changing the paperwork which would make recording formal consent easier for people and those with POA.

People had their food and nutrition needs met. One person said, "You can't fault the food, its lovely". Another person said: "The food is first class. You can have whatever you want. There are a couple of choices at meals". People's dietary preferences were catered for. People were happy with the food and portion size. One person said: "The food is good. I've never eaten so well in my life." Alternatives were available to the set meal choices. For example, we saw one person eating sandwiches for lunch. The cook was knowledgeable about providing people with a varied, balanced diet and food they enjoyed. The cook was kept up to date with people's changing dietary needs by the registered manager. Sandwiches, biscuits and cakes were available all the time along with a range of milky drinks, tea and coffee. We were told by the cook there was always a range of diabetic desserts and cakes. One person we spoke with had not been offered this choice by staff but this was addressed immediately. Where people required food to be pureed, soft or mashed it was presented in line with their care plan with the different food types kept separate.

Requires Improvement

# Is the service effective?

On Willow, Sycamore and Maple several people required support with their food. We observed one staff member on Willow assisted two people to eat at the same time and on Sycamore a staff member wiped excess food from people's mouths using a spoon rather than a napkin. The level of verbal interaction whilst assisting people varied considerably. There was little positive encouragement from staff or gentle prompting to eat. None of the staff talked to people about the food they were eating or informed them what was on their plate if people were not sure. On Maple, one person who required assistance with their food told us their food was brought and left while staff helped others. This meant their food could be cold. Therefore, for some people, the mealtime experience was poor which could have a negative impact on the person's health and wellbeing. This included how staff supported people with eating who could not support themselves. On Elburton lunch was a social event with people sitting together as they chose. Staff assisted one person, who preferred to eat in the lounge, by sitting alongside and engaging with them.

People were content their health needs were met. Records showed people had access to dental services, chiropody, eye health checks and hearing services. They also saw their GP and other community based health staff when needed. Visits by health and social care professionals were recorded. For example, visits by GPs, podiatrists, opticians, speech and language therapists (SALT) and social workers. Two health and social care professionals told us the staff listened to advice and put this into practice. They had only positive feedback to give us.

A visitor told us their relative had lost weight but had now regained their weight which they felt was down to the staff who they described as "fantastic". They also described the registered manager as "lovely" and "jolly". Another relative told us: "We had some concerns at first. It has certainly improved. Things have picked up. The staff are very good; they certainly look after my wife now."

One visitor told us that there was one hoist on Maple which delayed care as people had to wait for it to be available. This was raised with the registered manager who said they would review this to ensure there were enough hoists to meet people's needs in a timely manner.

Requires Improvement

# Is the service caring?

## Our findings

People were not always treated with kindness and respect by staff. During the inspection we observed contrasts in how staff spoke with and supported people. We saw and heard meaningful interactions that were mutually enjoyed by both the person and staff member involved. We also observed interactions of concern.

Some staff spoke about people rather than to or with them. For example, during one morning drinks round a staff member asked other staff, rather than the people themselves, what drinks people preferred. Staff replied pointing: "that person has or she has…" No one's name was used, neither was this discreetly handled. We also observed discussions between staff about people while they were present without them being involved in the discussions. For example, we observed a staff member supporting a person living with dementia to move around one unit. Another staff member joined them and both talked to each other about how the person had been that day. The person was observed looking from one staff member to the other. At no point did the staff involve the person in the discussion about themselves. A person who staff supported to get into bed stated: "They just do it and tell you afterwards" adding they had a hearing impairment and did not get a positive response from staff when they reminded them of this. Another person described one staff member as "brusque". They added: "Some staff are gentle and caring, and there are those who just want to get the job done." Another person who also required support to move told us: "The staff were not always gentle". This meant there were times when people were not being respected or looked after by staff in an appropriate manner. We discussed our concerns with the registered manager and regional manager. They told us they would raise the concerns with staff in handover and reiterate what was expected of staff in relation to treating people with respect.

People were not always involved with expressing their views or actively involved with making decisions about their care, treatment and support. For example, one person relatively new to the service commented that nursing staff had sought lots of information about them as an individual. However, they went on to say they had been asked again by other staff. They added: "They ask all about you, and you don't want to keep repeating it," indicating that despite telling the nurses they still had to tell other staff about their needs.

Other people spoke highly of the staff and considered them to be caring, kindly, gentle and understanding of people's needs. One person stated: "First class staff here. Nothing too much trouble for them – right on the ball, 100 per cent". Another person was positive about the day and night staff, saying "Nothing's too much trouble for them. It's so homely. I don't want to go to another home now." And, "I didn't want to do this, come here. All that went when I came here. The staff are so happy. They're well organised – there's no shenanigans." When we asked one person about staff attitude to them they told us: "You get one or two with a poor attitude, but very few" adding some staff were a bit short in their tone with them. When we asked if staff rushed them this person replied: "It just depends."

Staff ensured people's dignity and privacy were maintained at times of delivering personal care by ensuring that doors and curtains were closed. Staff knocked on doors and waited for a response before entering bedrooms. Several people in their rooms had their door open. A person on Elburton told us they could have privacy whenever they wanted it, as we asked about this on seeing their bedroom door was left open. Other people on Maple told us they preferred their door open.

People said they could have visitors at any time without restriction. One relative said, "We can visit any time after 10am; as the service likes to get people up first". Another relative said, "I come in the morning to be with my wife, have lunch and tea with her and leave around 7pm every day and am always made to feel welcome".

Requires Improvement

# Is the service responsive?

## Our findings

Prior to the inspection concerns were raised about the quality of the care planning in use across the service. We were told the care plans lacked personalisation and were so vast that it was difficult to trace how people's needs were being met. During our previous inspection we raised concerns about how the service was recording people's care. We asked the registered manager and provider how they were going to ensure this was addressed. An action plan told us a new care planning process would be introduced. This should have been in place before this inspection. We found this was not the case and concerns remained about the care plans in use.

People were not involved with planning their care and care plans were not personalised. This meant people's views were not gained nor did the recording demonstrate the care being given was how the person desired. Care plans were also difficult to follow and did not reflect how people were to be supported to remain independent. Where care was detailed this was not always delivered in a consistent manner. For example, one person desired to wash their face but required one member of staff to do everything else including oral care. They said all staff did not remember to allow them to wash their face or assist with their oral care as desired. Their need for a shave and what role staff took in this was not recorded; there was no reference to the person's preferences for bathing or showering and hair care in their care plan. This meant this person was not having their individual needs met.

This is a breach of Regulation 9 Health and Social Care Act 2009 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans in each unit were better organised than previously seen with guidance for staff where needs and responses should be written. For example, there was a guide on each file to support staff to remember where to log information. The registered manager also told us staff had attended briefing sessions on how to use the paperwork. However the care plans still contained a large amount of information and took a long time for staff to read. To find the essential details of what care people required and how this should be given was extremely difficult. Permanent staff told us they relied on staff handovers to ensure they were up to date with people's needs. New or temporary staff may find it difficult to follow the care plans. This meant people's needs may be missed or people may be at risk of inappropriate care. In discussion with us staff demonstrated they knew what people's individual needs were. However seven staff also told us that, although they knew about changes to people's care; they did not always record this due to the issues with the paperwork. This meant people's needs were not always being recorded to ensure continuity and consistency of care between staff.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monitoring charts were in place for people who required them. For example, we saw on Maple staff recorded when they assisted a person to change their position in bed. This included the times, side of the body moved to, and prompts for staff to record the condition of people's pressure areas. People's weight loss was monitored with a monthly record kept of people's weight. When weight loss was identified it was managed effectively by a referral to the GP. Food and fluid charts were also in place for people who required them.

Staff used other means to try and understand why behaviour may be different or challenging for people who could not communicate for themselves. For example, staff were mindful that changes in one person's behaviour, such as signs of confusion, could be a sign of infection. Records showed they had acted promptly and sought GP advice resulting in treatment for an infection. The staff also used a recognised pain scale to ensure people who could not ask for help were not in pain. For example, a person living with dementia was recorded in the daily records as shouting out. Staff had completed a pain scale and used simple questioning to establish if they were in pain and discomfort. The GP was also asked to visit. This meant this person's needs had been responded to quickly and appropriately.

Complaints were not always dealt with to ensure the service improved. Two people told us they felt their complaint was responded to by the registered manager but they weren't confident that concerns were acted on, as the problem continued. Complaints were clearly recorded as such and complaints were also monitored by head office. One person's care records showed the registered manager

Requires Improvement

# Is the service responsive?

had discussed their concerns with them, without recording in detail what these were. When we spoke with them they stated concerns continued. There was no record in the complaint file of these later concerns which they stated had been raised with the registered manager.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

The home's complaints policy stated that issues arising from complaints would be a standing agenda item for discussion at team meetings, to promote learning and improvement of the service. This was not recorded in the minutes of meeting records available, therefore it was not possible to show what learning from events had taken place to ensure the concerns were not repeated. All staff said they were aware of the home's complaints policy and procedure. They said they took all complaints seriously and reported to the nurse on duty, unit manager or registered manager. They explained how they recognised when people, who were unable to express themselves verbally, were unhappy about something. They read their body language or interpreted their mood. We did not see any complaints from staff in the service's complaints file. The registered manager told us they were recorded separately, and that she would ask for statements if necessary, to enable further investigation or follow up.

People had a choice of a weekly bath or a shower and said they only had to ask if they wanted more. Some said staff suggested whether they should take a bath or shower. People were dressed in clean clothes with attention paid to personal hygiene, hair and fingernails.

A GP told us they were impressed by the care and support provided by staff for a particular person who had complex needs. They went on to tell us the staff had been able to meet the person's needs and stabilise their condition.

Everyone was not provided with the same level of opportunity to take part in activities. The service employed one full time and two part time activity coordinators who were busy when we were at the home. For people living with dementia on Sycamore on the first day of our visit, there was nothing for people to do either together or by themselves. On the second day, magazines and papers were provided in the morning. Across the service everyone had a written personal history but this did not always lead to a personalised activity programme. Activity staff agreed they were limited in time to meet people's individual needs.

People who could tell us their experience spoke appreciatively of the activities available to them. One family member said: "There are not enough activities going on here. The other day a carer was putting up wallpaper rather than meeting my husband's needs; they told me they couldn't go to him." The also told us: "The weekends are dead; nothing happens on Saturdays and Sundays. Nothing, nothing at all." They told us they had asked for a photocopy of the activity list so they could talk about with their relative, but said this still had not happened. They said this would be important to him as "he forgets". There was a universal timetable of activities advertised in the front entrance and lift only. The registered manager told us they would look at how they could improve this for people.

People's care records included their faith details. People were supported to practice their faith and maintain links with local religious leaders and organisations. Volunteers from a local church supported people to attend services if they wanted to. Religious services took place at regular intervals in a group or one to one basis depending on choice.

Requires Improvement

# Is the service well-led?

## Our findings

The service is run by Four Seasons (DFK) Ltd which is part of a large national organisation. We were advised that the wider organisation of 'Four Seasons' had reorganised since we last visited the service and the new structure was settling in. The registered manager and regional manager said they felt this would bring a better outcome for people and staff at Springfields Care Home but it was too early to evidence whether this was the case.

The service had a local leadership model in place. This was made up of a registered manager, deputy manager and unit managers. Where responsibilities were delegated by the registered manager there were several times when it was difficult to see the task had been completed. For example, when trying to establish who was responsible for completing internal audits and staff supervision, appraisal and observations it was not possible to demonstrate this task had been completed or checked to ensure they were taking place. The regional manager, who was new in post, said they would undertake an audit of the roles currently in use to ensure there was a clear structure in place and staff and management knew what their responsibilities were.

All staff told us they felt the leadership at the local level in the home was fine. A comment we received in respect of the wider organisation was: "Above the local level there is no system of managers above [the registered manager]. No managers from Four Seasons walk the floor; they don't know us." Also from another member of staff: "[The registered manager] is always willing to listen. I feel the service is well run but we never get any communication from Four Seasons; they don't know the service or visit. I don't know who is who in Four Seasons." None of the staff we spoke with felt part of the wider organisation of Four Seasons. They did not feel they knew or understood the shared values and practice Four Seasons required of them. The regional manager agreed to look at these issues and raise them centrally with Four Seasons' senior management.

Registered managers are required by Four Seasons to complete returns on certain aspects of the running of the service as part of their quality audit. Some of the aspects we raised as a concern during this inspection were identified in these returns, however there was no evidence these were then acted on by head office. For example, staff receiving dementia awareness training; issues with care planning and not reflecting people's personal choices; and ensuring a quality dining experience had been mentioned as a concern since January 2014. No action plans were in place to show how these issues would be improved for people. The area manager stated they would raise this with senior managers.

People, relatives and staff identified the registered manager as being in charge. People on Elburton said they saw her most days whilst someone on Maple said they saw her twice a week. A person on Elburton told us "managers" came round and they could speak to them if they wanted, saying: "That's what they're here for." A visitor told us they could visit freely, saying: "They keep us involved with what's going on." They gave the example of being told about changes in their relative's health, which they said staff addressed promptly. When we asked if they were informed about the service and any changes generally, they told us the registered manager was often around doing this.

Two visitors told us resident meeting minutes were sent out by the staff, though one said it was a year ago. Different relatives said they thought the occasional meetings of relatives and residents with management were worthwhile as the latter listened and took action if at all possible.

There was an annual audit of medicines management by an external pharmacist. This included an action plan we could see had been acted upon. There were also other audits of the premises and equipment in place. Where required action had been taken and resolved. For example, the external decking area had been fenced off and access restricted. We were told this would be repaired or replaced as soon as possible. People had been told about this and shared with us the plans in place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**Regulation 9(1)(b)(i)**<br>**which corresponds to Regulation 9(3)(b)-(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br>**The registered person had not taken proper steps to ensure each person had their care planned and delivered in a way to meet their individual needs.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints<br>**Regulation 19 (1)((2)(c)**<br>**which corresponds to Regulation 16(1)(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br>**The registered person did not have an effective complaints system in place to ensure any complaint was fully investigated and, as reasonably practicable, resolved to the satisfaction of the person or person acting on their behalf.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>**Regulation 20(1)(a)**<br>**which corresponds to Regulation 17(2)(c)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** |

This section is primarily information for the provider

# Action we have told the provider to take

The registered person had not taken appropriate steps to ensure people were protected from unsafe and inappropriate care or treatment arising from lack of information on them by means of an accurate record in respect of each person which included appropriate information and documents in relation to the care of each person.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>which corresponds to Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br><br>The registered person had not taken appropriate steps to ensure there were, at all times, sufficient numbers of staff to meet people's personal care needs appropriately. |