Ascot Care North East Limited

Springfield Lodge Nursing Home

Inspection report

North Street
West Rainton
Tyne and Wear
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 May and 1 June 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

Springfield Lodge Nursing Home provides care and accommodation for up to 37 people with personal care and nursing needs. On the day of our inspection there were 34 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Springfield Lodge Nursing Home was last inspected by CQC on 31 July 2014 and was compliant with the regulations in force at that time.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. Staff had been trained in how to safeguard vulnerable adults. Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act (MCA) 2005 and was following the requirements in the Deprivation of Liberty Safeguards (DoLS).

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service were complimentary about the standard of care at Springfield Lodge Nursing Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they moved into Springfield Lodge Nursing Home and care plans were written in a person centred way.

The home employed an activities co-ordinator and activities were arranged for people to help meet their social needs and protect people from social isolation.

People who used the service were aware of how to make a complaint. There had been only one formal complaint recorded at the service in the previous 12 months.

The service had links with the local community. Staff felt supported by the registered manager and were comfortable raising any concerns. People who used the service and staff were regularly consulted about the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people who used the service.

Staff had been trained in how to safeguard vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff in making healthy choices regarding their diet.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into Springfield Lodge Nursing Home and care plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the local community.

Springfield Lodge Nursing 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 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 May and 1 June 2016 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff, and Healthwatch. No concerns were raised by any of these professionals.

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 used this information to inform our inspection.

During our inspection we spoke with six people who used the service. We also spoke with the registered manager, three care staff and one domestic staff member.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also carried out observations of people and their interactions with staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Springfield Lodge Nursing Home.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working at the home. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, utility bills, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the registered manager and looked at staff rotas. A dependency tool was used to calculate staffing levels. This was carried out by the registered manager on a monthly basis and calculated whether people had low, medium or high dependency. Staffing levels we saw were always higher than the calculated level. Each shift had a nurse on duty. The registered manager told us agency staff were occasionally used at the service however this was a last resort as permanent staff were flexible and the service had access to their own bank staff.

People and staff we spoke with did not raise any concerns about staffing levels at Springfield Lodge. This meant there were enough staff with the right experience, skills and knowledge to meet the needs of the people who used the service.

The home is a detached building, set in its own grounds. All the accommodation and facilities were on the ground floor. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. The large conservatory and dining room provided easy access to outside areas for those people with wheelchairs or walking aids and an external, safe patio area was available for people to use. 19 of the bedrooms were en-suite and there were adequate communal toilets and bathrooms available throughout the home.

The home was clean, free from odours and appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. The laundry was large and had two separate areas for soiled and clean laundry. All the clean laundry was stored on shelving in individual sections for each person who used the service. We found that the floor edging in one of the communal toilets needed replacing. We discussed this with the registered manager who told us the toilets and bathrooms were being refurbished as part of the home's refurbishment plan. This meant people were protected from the risk of acquired infections.

Up to date risk assessments were in place for people who used the service and described potential risks and the safeguards in place. Risk assessments included mobility and risk of falls, use of wheelchairs and mobility equipment, pressure area care, risk of isolation and use of profiling beds. We saw one person was at risk of falls due to disorientation, memory loss, environmental and other physical factors. Control measures were put in place to reduce the risk and included staff regularly monitoring and assessing the person, ensuring the person's surroundings were clutter free, ensuring the person wore suitable footwear and clothing, regular eye and hearing tests took place and a sensor mat was placed beside the person's bed to alert staff if the person was getting out of bed unaided. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance, Health and Safety in Care Homes (2014). Safe hot water temperature guides were on bathroom walls and thermometers were available.

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire risk assessments were in place, fire alarm and emergency lighting tests took place regularly and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy and looked at the safeguarding file, which included local authority safeguarding notification forms and risk threshold tool. The file contained records of all safeguarding incidents that had occurred at the service and we saw that CQC had been notified of all relevant incidents. Staff were trained in safeguarding vulnerable adults and the registered manager understood their responsibilities.

The provider had a 'Prevention and management of falls' policy and carried out monthly analysis of accidents that had occurred at Springfield Lodge Nursing Home. The analysis included dates and times, location, cause, injury sustained and outcome.

We looked at the management of medicines and saw medicines were stored in locked trolleys in a locked treatment room. Controlled drugs were stored in a separate locked cabinet. Controlled drugs are medicines which may be at risk of misuse.

Each person who used the service had a medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and records when they have been administered. For each person there was a front sheet, which included an up to date photograph of the person and a record of their name, date of birth, GP contact details and any allergies. Each person also had a medicines preference sheet, which described how the person preferred to take their medicines. The MARs were colour coded depending on the time of day the medicine was to be administered. All the MARs we saw were accurate and up to date.

Treatment room and refrigerator temperature checks were recorded daily, were up to date and within recommended guidelines.

Medicine administration competency checks were carried out on a regular basis and included whether staff identified the person appropriately, appropriate checks were carried out before medicines were administered, all medicine administrations were recorded correctly, medicine refusals and self-

administered medicines were recorded, the medicines trolley was secure at all times and a system was in place for reporting medicine administration errors. Audits were also carried out of medicine administration records and labelling of medicines, ointments and creams.

Monthly medicine audits were carried out by the registered manager and checked whether medicines had been correctly administered and signed for, that stock and quantities were accurate, whether medicines were correctly dated, that staff signatures were checked and that any previous issues had been actioned appropriately. A monthly treatment room audit was also carried out by one of the nurses. This checked MAR charts, the medicine trolleys, cupboards, fridge and general cleanliness of the treatment room. We saw these monthly audits were up to date.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at Springfield Lodge Nursing Home received effective care and support from well trained and well supported staff. People who used the service told us, "I'm very well looked after" and "It's lovely".

Records we looked at showed staff had received training in safeguarding vulnerable adults, moving and assisting, health and safety, first aid, food hygiene, mental capacity, control of substances hazardous to health (COSHH), infection control, end of life, equality and diversity, challenging behaviour, nutrition and dignity. Nurses employed by the service received additional training in administration of medicines, verification of death, pressure care awareness and emergency response.

New staff at Springfield Lodge Nursing Home completed an induction to the service, which included an introduction to the home and training required to perform the role. The registered manager told us new staff would be enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

Staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. The registered manager had a staff supervision and appraisal planner, which allowed them to track any that were due. Staff had signed supervision contracts, which explained what the purpose of a supervision was and they would take place every three months. Staff records we looked at showed they received a supervision every three months.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining room at meal times when required. The service operated a four week menu and people were supported to eat in their own bedrooms if they preferred. A 'Hydration bar' was available all day for people to access cold drinks.

People's dietary needs and likes and dislikes were recorded in the care records. For example, it was identified on admission to the home that one person required a soft diet and thickened fluids due to significant weight loss in hospital and problems with swallowing food. The person's needs were clearly recorded in their 'Eating and drinking' care plan and the planned care described what action staff had to take. For example, encouraging the person to attend the dining room for their meals, ensuring the person had drinks to hand, weighing the person on a weekly basis and ensuring the person had a pureed diet with thickened fluids. Care records included records of dietitian and Speech and Language Therapy (SALT) consultations and guidance. A malnutrition universal screening tool (MUST) was used to monitor the person's weight, body mass index (BMI) and risk of undernutrition. These records were up to date. This meant people who used the service were protected from the risks of malnutrition.

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 when this is in their best interests and legally authorised under the MCA. The application 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 whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the registered manager, who was aware of their responsibilities. The registered manager told us they were in the process of applying for a DoLS for a new resident. 12 applications for other people who used the serviced had been submitted to the local authority. Six of these had been authorised and the registered manager was waiting for the other DoLS assessments to be carried out. Notifications of the authorisations had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

The registered manager was aware of their responsibilities in accordance with the MCA. People they supported had varying capacity to make decisions and where they were unable to make a specific decision action had been taken to ensure relevant parties were involved in making best interest decisions. We observed that the service had sought consent from people for their care and support as well as to share confidential information. We saw copies of signed consent forms in people's care records.

Some of the care records we looked at included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which meant if a person's heart or breathing stopped as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These forms were up to date and showed the person who used the service, family members and relevant professionals had been involved in the decision making process.

People also had emergency healthcare plans (EHCP) in place, which contained information to help communication in an emergency and to ensure timely access to the right treatment and specialists.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GP, district nursing team, chiropodist, dentist, SALT, physiotherapist, optician and dietitian.

Some of the people who used the service were living with dementia. We looked at the design of the building for people living with dementia and saw people's bedroom doors were clearly signed with a room number and the person's name. Some people had used memory boxes on the wall outside their bedroom to display photographs and items that were important to them. Although bathroom and toilet doors were the same colour as bedroom doors, these were clearly signed. Signs with arrows were on corridor walls directing people to the lounge or dining room. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the standard of care at Springfield Lodge Nursing Home. They told us, "The girls are lovely" and "It's a lovely home".

People who used the service were asked what name they preferred to be known as. This was clearly displayed on people's bedroom doors and on the front page of the care records. Each person had a 'Resident choices and preferences checklist' in their care records. This included whether people preferred a bath or shower, what aspects of personal care they required assistance with, whether the person preferred male or female care staff, bed times, eating and drinking preferences, things the person liked to do and financial wishes. The records we saw were signed by the person who used the service or a family member if the person was unable to.

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. We observed staff assisting people to get ready for an outing in the provider's minibus. Staff provided verbal encouragement and supported people to go outside.

People were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people's individual needs. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. People we spoke with told us staff respected their privacy and dignity.

In the 2016 residents' questionnaire, people were asked about privacy and dignity in two questions; "Do staff show you compassion, dignity and privacy?" and "Do staff knock before entering your room?" Both questions were answered "Yes" by all 16 respondents. Staff told us they respected people's privacy and dignity by knocking on people's doors before entering, closing the door behind them and carrying out personal care in the person's own private bedroom. This meant that staff treated people with dignity and respect.

People were supported to be independent. One person who used the service told us they were recovering from a hip operation and staff encouraged them to mobilise independently around the home. They told us, "They encourage me" and "They let me take my time".

Bedrooms were individualised, some with people's own furniture and personal possessions. The provider's statement of purpose stated there were no set visiting hours and friends and family members were encouraged to visit at any time. People we spoke with confirmed this. This demonstrated the registered manager had successfully ensured people were able to feel at home.

The registered manager told us none of the people who used the service had advocates as those people who were not able to make their own decisions about their care had family members, who were consulted about best interest decisions.

People had 'Spiritual' care plans in place, which recorded people's requests regarding spiritual needs, for example, whether the person was religious and what faith they followed, whether they wanted to attend church or have contact with a priest or religious member and whether they wanted to discuss their religious beliefs.

End of life care plans were in place and recorded people's end of life wishes. The service acknowledged this was a delicate subject but felt it important to discuss with people what their end of life wishes were and record them. This meant people had been able to be involved in their end of life care.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated. These reviews were signed and dated, and up to date.

People's needs were assessed before they moved into Springfield Lodge Nursing Home. Admission sheets were included in people's care records and provided important information on the person such as details of next of kin, GP and consultant, diagnosis and history of present illness, allergies, medication on admission and the person's, and family members', perception of their current health status.

Physical health initial assessments were also carried out and included mobility, dietary needs, bowel and bladder control, speech, hearing and sight, rest and sleep, skin, breathing, washing and bathing and dressing. This ensured staff knew about people's needs before they moved in to the home.

Each person's care record included a 'This is me' leaflet, which provided information about the person such as things that were important to the person, a summary of the person's life, what they liked to do and what assistance they needed for various aspects of their care. We saw that this had been written in consultation with the person who used the service and their family members.

Care plans were in place, were up to date and reflected people's changing care needs. For example, one person was identified as being at risk of neglect and compromised skin integrity due to decreased mobility. The person's care plan described the personal care the person was to receive and what actions staff were to take to achieve the person's personal hygiene wishes and to reduce the risk of compromised skin integrity. For example, assistance with showering and applying prescribed creams, monitoring of skin integrity during bathing and the completion of a monthly waterlow record. Waterlow is a risk assessment tool that calculates the person's risk based on categories such as skin type, continence, mobility, appetite, tissue malnutrition and medication. These records were up to date.

Daily notes were completed for each person who used the service and recorded any important information such as details of overnight checks, bowel movements and continence.

The service employed a full time activities coordinator. An activities timetable was displayed in the building and included bowls, velcro darts, arts and crafts, singers, dominoes and keep fit. The registered manager told us, "I like to hear laughter." The service had its own minibus and people were regularly taken out on external activities such as local attractions, the seaside and shops. People we spoke with told us there were lots to do at the home and they went out on external activities. One person told us they were content to stay in their own room but could take part in activities if they wished. This meant people who used the service were protected from social isolation.

We saw the complaints file, which included a copy of the provider's complaints and concerns policy and procedure. This provided information about the procedure to be followed and the action to be taken when a complaint was received.

We saw people who used the service had copies of the complaints procedure in their bedrooms and information was provided on compliments, comments and complaints in the entrance to the building. The service user guide also included information on the complaints procedure and who to contact if people were not happy with how their complaint was dealt with, for example the local authority and the local government ombudsman.

Only one complaint had been received by the service in the previous 12 months. We saw a copy of the complaint record, letter of response to the complainant acknowledging the complaint and letter to the complainant with the outcome of the complaint, including what action was taken. People we spoke with were aware of the complaints procedure but did not have any complaints. This showed the provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

The service had a positive culture that was person-centred, open and inclusive. Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. Staff also told us the home was, "So relaxed" and "Peaceful".

Staff were regularly consulted and kept up to date with information about the home and the provider. A staff survey had taken place in October 2015 and included questions on training and induction, being part of a team and feeling valued, management approachability, job satisfaction, safeguarding, complaints and policies and procedures. The majority of questions had a 100% satisfaction rate.

Staff meetings took place every three months. We looked at the minutes of the most recent meeting in May 2016, which included discussions on DoLS, end of life, care plans, escorting people to hospital, staff issues and the kitchen. Each staff meeting record had a signature sheet for staff to sign to say they had read the minutes. Additional meetings also took place for the nursing staff.

The service had links with the local community, including the local church and primary school. Local primary school children visited the home regularly, for example, at Christmas, mother's day and father's day. People who used the service had been invited by the local jubilee hall to attend a celebration for the Queen's 90th birthday.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The registered manager had an audit schedule and monthly audits included quality dining, workplace health and safety inspection, domestic inspection audit, wheelchair audit, medicines, kitchen and safe food handling, and care plans. Care plan audits were carried out by the registered manager and checked whether the care plan was satisfactory in all respects, whether specific improvements were required or whether the care plan was unsatisfactory and required considerable improvements.

These audits were checked by the provider's compliance manager, who visited the home weekly to give support and carry out their own audits. These visits included auditing records and talking to people who used the service and staff. Action plans were produced for any identified issues and allocated to the relevant member of staff.

Twice daily walk around checks were carried out by the registered manager. These checked staffing and staff skill mix, the tidiness of the accommodation, cleanliness of equipment and whether bathrooms and toilets were clutter free.

Residents' meetings took place every three months. The most recent meeting took place in March 2016 and subjects discussed at this meeting included the new conservatory, menu and activities. The registered

manager asked people if there were any changes they would like to see at the home, to let them know.

In order to monitor the effectiveness of the service, evaluation forms were provided in the entrance to the home for family members and visitors to complete. These included questions on the accommodation, services provided at the home and communication, for example, do family members feel involved in decisions about care and how family members rate communication from staff.

Questionnaires had been provided to people who used the service, friends and family and visiting professionals and we saw the results from 2016. People who used the service were asked questions on the accommodation, staff, cleanliness, quality of care, food, communication, dignity and privacy and activities. Family and friends were asked questions on the accommodation, staff, communication and information and whether they would recommend the service to others. Visiting professionals were asked about staff attitude, care records, availability of management, odours and whether people who used the service appeared to be well. The majority of responses were positive and additional comments were complimentary about the home and the staff.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources.