Hatzfeld Care Limited

Spring House Residential Care Home

Inspection report

21 Eastbourne Road
Hornsea
East Riding of Yorkshire
HU18 1QS

Tel: 01964533253

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Spring House is registered to provide accommodation and personal care for up to 21 older people, some of whom may be living with dementia. The accommodation is over three floors, with a lift to the first floor and chair lift to the second floor. It is located in the seaside town of Hornsea.

The inspection took place on 23 and 28 March 2017. The first day of the inspection was unannounced.

The service was registered in September 2015, and this was its first rated inspection. The service had been temporarily closed for refurbishment between May and November 2016, so had been re-open for four months when we visited. At the time of our inspection 17 people used service.

The registered provider is required to have a registered manager and 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.

There were policies and procedures in place to ensure people received their medicines but these were not always consistently followed and systems in place were not sufficiently robust. This was a breach of legal requirements. Quality assurance processes had not identified or addressed a number of issues we found during our inspection, in order to drive improvement. This was also a breach of legal requirements and you can see the action we have asked the provider to take at the back of the full version of this report.

There were systems in place to help make sure people who used the service were protected from the risk of abuse. People's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. However, not all risk assessments had been reviewed in a timely manner. Improvement was required to the recording and analysis of incidents at the service, in order to ensure the risk of reoccurrence was minimised. More detail was required in some behaviour management care plans, to give clearer guidance to staff of how respond when people presented distressed behaviours. We did see that staff responded calmly and appropriately to incidents that occurred during the inspection.

The home had undergone extensive refurbishment in the year prior to our inspection and the registered provider employed domestic staff. However, we found some areas of the home were untidy and had not been cleaned effectively. Some of these issues were addressed during the inspection. We have made a recommendation that the registered provider takes action to ensure best practice in relation to infection prevention and control is consistently followed.

The registered provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. There were mixed views about whether there were sufficient staff to meet people's needs. After re-opening the service in November 2016 a significant number of people had moved

into the home in a relatively short period of time. We found the registered provider had recruited new staff in order to meet the needs of the increased numbers of people and they had contingency arrangements in place until additional new staff were in post.

Staff received an induction, training and supervision to enable them to provide effective care for people, although there were gaps in the recording of recent supervisions.

Staff were able to demonstrate an understanding of the importance of gaining consent before providing care to someone. However, Deprivation of Liberty Safeguards (DoLS) applications had not been submitted for all people who required an authorisation to deprive them of their liberty. The registered provider addressed this during the course of our inspection and was taking action to improve knowledge and understanding in relation to Mental Capacity Act and DoLS requirements.

People told us staff were caring and we observed positive, warm and friendly interactions between people and staff. People were involved in decisions about their care and we observed people being offered choices, such as what they wanted to eat. People's privacy was respected.

Care plans were developed to give staff the guidance they needed to support people, but not all of these had been reviewed in a timely manner. There was limited evidence of varied activities available to people at the home, but we were advised of plans to increase the range of activities and outings.

We found that people were supported to access healthcare services. Support was also provided in relation to people's nutritional needs and people were satisfied with the food available.

There was a complaints procedure in place and people were able to raise concerns.

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.

Systems to ensure people received their medicines safely were not robust as policies were not always consistently followed. Risks to people were assessed and managed but improvement was required in relation to the recording of incidents and ensuring risk assessments were reviewed in a timely manner.

Some areas of the home required closer attention with cleaning and we have made a recommendation that the registered provider takes action to ensure appropriate standards of hygiene are consistently maintained.

Recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training, supervision and appraisal to enable them to provide effective care for people, but improvement was required in relation to the recording of supervisions.

Staff were able to demonstrate an understanding of the importance of gaining consent before providing care to someone but improvement was required to ensure consistent implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported with their nutritional needs and had access to healthcare services in order to maintain good health.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and we observed positive, warm interactions between people who used the service and staff. Staff provided reassurance when people were distressed.

Staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was responsive, but some improvements were required.

Care plans were in place outlining people's care and support needs but these were not always kept up to date.

People who used the service were supported to take part in some activities, but there was opportunity for further development in this area.

People were able to raise concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post and staff told us they received support from management.

The registered provider conducted a range of audits in order to monitor the quality of the service provided. However some of the issues we identified in our inspection had not been identified and addressed via quality assurance processes, which showed that these processes were not sufficiently robust.

Spring House Residential 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 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.

The inspection took place on 23 and 28 March 2017 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience on the first day of the inspection and one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our visit, we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from the local authority's quality monitoring team.

Prior to the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with four people who used the service and four visitors. We also spoke with two care staff (one of whom was also a domestic staff member), the care manager, the deputy manager and the registered manager. We also spoke with the deputy manager and the manager of one of the registered provider's other services locally, who assisted with the provision of information for the inspection. We looked at three people's care records, two people's medication records, three staff recruitment and training files and a selection of records used to monitor the quality of the service. We spent time in the communal areas of the home on the first day of our inspection and observed staff interacting with people who used the service on both days of the inspection.

Requires Improvement

Is the service safe?

Our findings

One person who used the service told us, "It's the camaraderie among the staff that makes me feel safe." Our observations suggested people felt comfortable and relaxed with staff, although on the first day of our inspection one person was very agitated for periods of the day, which was not conducive to a calm and relaxed environment for others living at the home. Staff provided appropriate support to this person throughout the day to try and calm them and reduce their anxiety.

We looked at systems in place to ensure people received their medicines safely. Staff responsible for administering medication were trained in medicines management and were observed administering medicines after completing their training, to check their competence. Medicines were stored appropriately.

We looked at a selection of Medication Administration Records (MARs). We found these were not always consistently completed and there were some gaps. Some medicines were prescribed for use 'as required', and there was inconsistency in whether staff recorded when these had been offered. We were advised that this issue had also been identified in a recent medication audit, so clarification had been given to staff about this to resolve the issue. There were no protocols in place in relation to 'as required' medicines and prescribed creams, to give guidance to staff on when these were needed. The registered manager told us they were in discussion with the GP about whether some of these prescriptions were still required, and told us once the requirement for these medicines had been reviewed they would develop protocols for any that were still required.

Most medicines were supplied in MDS (monitored dosage system) packs, but some other medicines were supplied in their original packaging. We were unable to check that the stock balance for two of these medicines tallied with the stock level recorded on the MARs, because staff had failed to record the number of tablets that were already in stock at the start of the medication cycle. This meant the registered provider could not check that the medicines had been administered as recorded on the MAR. The label on one bottled liquid medicine had rubbed off, so it was not possible to read the name of the person the medicine was for or the administration instructions. The deputy manager removed this medicine and immediately requested a new bottle from the pharmacy. We saw that one medicine for one person had been out of stock since the start of the current medication cycle 15 days earlier. We were told that a message was left for the GP as soon as it was discovered that the medication had not been delivered, at the start of the medication cycle, to check if the medicine was still required. However, staff had not chased this again until two weeks later (the day before our visit). The registered provider had only conducted one medication audit between the service re-opening in November 2016 and the first day of our inspection on the 23 March 2017. However, an external medication audit, conducted by a pharmacist, took place in between the two days of our inspection.

This showed us that the systems in place to ensure people received their medicines safely were not robust and procedures were not consistently followed. This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were advised that the registered provider would be commencing weekly checks and monthly medication audits from the week following our inspection and that they were planning to introduce a new electronic medication recording system.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. They also had a copy of the local authority's new safeguarding concerns tool and multi-agency policy and procedure. Staff received training in safeguarding and understood the different types of abuse that could occur. Staff told us they would report any concerns straightaway to the registered manager. The registered provider had not made any safeguarding referrals to the local authority in the year prior to our inspection. We asked the registered manager if the home used the local authority's safeguarding tool to assess whether certain incidents, such as incidents of aggression between people who used the service, required a safeguarding referral to the local authority. We were told they did, but we did not see evidence of this.

The registered provider had a robust system for the recruitment of staff. We looked at recruitment records for three staff and found that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. The registered provider also conducted interviews and completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We spoke with staff, visitors and people who used the service to gain their views about whether there were sufficient staff to meet people's needs safely. There were mixed views about this. One relative told us, "[My relative] needs prompting to drink and eat. There's not enough staff to meet their needs. But they are bringing staff on board and training them." Another relative told us, "They do the best with the staff they have. Sometimes the staff are rushed off their feet." Staff told us, "Staffing levels are usually okay, but it's tight when someone phones in sick" and "We could do with a couple more staff some days. We are getting there with staffing. It has increased since we've had new people move in."

During the inspection, there were staff available in the communal areas and we observed staff going to check on people who were in their rooms. We did however, have some concern that a significant number of people had moved in to the home in a short period of time, some of whom displayed behaviours which could be challenging to others. Seven new people had moved into the home in the three months prior to our inspection. Although new staff had been recruited to respond to this increase in numbers, including a new deputy manager, not all of the new care staff had started work at the time of our inspection.

On the first day of our inspection there were three care staff on duty, as well as the deputy manager, who also provided care. There was also a cook on duty. Additional management staff came to the service, to support with the inspection. One of the people who had very recently moved in to the home required one to one support during day time hours, and potentially up to three staff when particularly distressed or receiving personal care. We discussed with staff how they ensured other people had sufficient support during periods when this person needed the support of three staff. Staff were able to describe how this was managed within the current staffing resources. The registered manager told us there was normally a care manager on duty in addition to the care staff and deputy manager, plus the team could call upon specialist behaviour support staff who were based at one of the registered provider's other local services. We saw that this additional specialist support was used on the first day of our inspection, when one person was experiencing distressed behaviours throughout the day.

We were advised two new care staff were due to start work the week after the inspection, and we were shown rotas to illustrate there would be an additional care staff member each day in due course. We discussed with the registered manager the importance of ensuring there was sufficient staff flexibility in the meantime, such as the additional specialist support staff to call upon, to ensure people's safety and well-being at all times. The registered manager confirmed that staffing levels would continue to be regularly reviewed according to people's needs. We will continue to monitor this at future inspections.

The registered provider developed risk assessments in relation to people's individual needs. These included assessments regarding the risk of aspiration, challenging behaviour, self-harm and skin integrity. The risk assessments guided staff in how to respond and minimise risk. We were advised the registered provider's policy was to review risk assessments monthly, but one person's risk assessments had not been reviewed since December 2016. This person's relative told us that their relative had had three falls since December 2016, but we found their falls care plan had not been updated since 1 December 2016. The deputy manager agreed to update this, and told us that one of their key priorities since coming in to post was to ensure all care plans and risk assessments were up to date. Another person's file, that we saw on the first day of our inspection, did not contain risk assessments. We were advised this was because the person had only moved into the home three days earlier and that the documents were on the computer and due to be finished and printed off that day. We looked at the assessments on the computer. We noted that the person's risk assessment for challenging behaviour lacked detail regarding the specific behaviour management strategies staff should use to prevent, and to respond to, distressed behaviours. The registered provider updated the assessment and sent us a copy of this after the inspection. They told us they would continue to develop further detail in the care plan and risk assessments as they got to know this person better.

We saw records of accidents or incidents were completed by staff. The registered manager had recently started reviewing all accident and incident records to ensure that appropriate action had been taken. Two incidents occurred on the first day of our inspection, one of which involved an act of physical aggression by a person using the service towards another person using the service. The other involved a visitor. Both incidents were promptly and appropriately dealt with by staff. When we returned for the second day of our inspection, we checked the records in relation to these incidents. There was no record in relation to the incident with the visitor and the record in relation to the incident between people who used the service did not contain full detail and analysis of the all information that was available to staff at the time. This showed that opportunities to learn from incidents, in order to prevent recurrence, had been missed. We spoke with the registered manager about this, who agreed to discuss this further with staff and ensure all incidents were thoroughly documented and analysed in order to minimise the risk of recurrence.

We reviewed documents relating to the servicing of equipment used in the home and maintenance of the environment. These records showed us that equipment was regularly checked and serviced. This included the fire alarm, fire extinguishers, gas installations, emergency lighting and electrical wiring.

The registered provider had invested in an extensive refurbishment of the property in the year prior to our inspection. The registered provider also had an infection control policy and employed domestic staff. On the first day of our inspection we found some infection control risks and areas of the home that required greater attention with cleaning. For instance, the laundry was untidy and there was no clear separation between the clean and dirty laundry storage areas. The cleaning cupboard was very untidy and disorganised, with inappropriate items such as paper towels and old mops stacked on the floor. This meant the floor could not be easily cleaned. One bathroom had inappropriate items stored in it, such as a wheelchair and boxes, and there was no suitable foot operated pedal bin. The floor in another bathroom was dirty. The deputy manager ensured this was cleaned straightaway. By the second day of the inspection, we saw that the cleaning cupboard was significantly tidier; excess stock had been removed and the contents were easier to

access. Inappropriate items had been removed from the bathroom. The registered provider advised us they planned to purchase a property locally, which would be used as a laundry for the registered provider's three services in Hornsea, including Spring House. This would also free up space in the existing laundry room to give the service more storage space.

We recommend the registered provider ensures best practice guidance in relation to infection prevention and control is followed at all times.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service whether they were happy with the care they received and whether they thought staff had the right skills for the job. People's comments included, "They (staff) are good, very very good." Relatives told us, "They (staff) take everything on board. The staff have adjusted to [my relative]'s need, all credit to them" and "I think they look after them very well."

We looked at induction and training records to check whether staff had undertaken training on topics that would give them the skills and knowledge they needed to care for people who used the service. These records showed that staff completed an induction when they started in post, along with training in a range of topics considered essential by the registered provider. This included health and safety, first aid, manual handling, medication, safeguarding vulnerable adults and food hygiene. Staff received MAPA training (Management of Actual and Potential Aggression) or training in challenging behaviour awareness and breakaway techniques. Some staff also had a variety of other training in topics such as mental health awareness, dementia, nutrition, falls awareness, pressure ulcer awareness and end of life care.

Staff completed refresher training to ensure their knowledge and skills were kept up to date. The registered provider stored training records electronically on a training matrix and training certificates were held in staff files. Staff told us that some of their training was done on-line and some was face to face. One member of staff told us, "We've had some training on managing challenging behaviours. A gentleman came to do some demonstrations, including breakaway techniques to use if needed. We are trying to get strategies drawn up so we can refer to these for each person, including where to stand, et cetera, so we can react quickly." They also confirmed they could ask for additional training if they felt they needed it.

Team meetings were usually held monthly. Handover meetings were held twice a day to exchange key information between staff and we saw that a new format for recording information passed over during handover meetings had recently been developed. We were told all staff had received supervision since the start of January 2017, and were provided with the dates of these meetings, but in the three staff files we reviewed there was no record of these supervision meetings. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice.

This showed that people were supported by staff that had the knowledge and skills to care for them effectively, but improvement was required in relation to the staff supervision systems.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff we spoke with were aware of the importance of seeking consent before providing care to people, and we observed that they sought consent and involved people in decisions when providing care. Care files also contained a 'decision making matrix' which guided staff on how to communicate with people and indicated when it was a good time to ask them about decisions.

On the first day of our inspection we found that there was a DoLS authorisation in place for one person. However applications to deprive people of their liberty had not been appropriately made for some other people who required them. One person's file contained a DoLS authorisation which had been granted when they were temporarily living in one of the registered provider's other services up to November 2016. DoLS authorisations should be specific to the circumstance and location, so this authorisation was not valid for Spring House. The registered provider took prompt action to rectify this and when we returned for the second day of our inspection they had submitted applications for seven people. Care files did not contain evidence of mental capacity assessments, but the registered provider showed us an example of the template they used. We requested further information about the registered provider's procedures in relation to the MCA and DoLS, and the information we were sent did not fully reflect the principles of the Act and current best practice. The registered manager acknowledged there were errors in this and agreed to ensure other managers and staff were made aware. They also told us that they, and two other management staff were booked on additional MCA and DoLS training shortly after our inspection.

We recommend the registered provider seeks advice from an appropriate source regarding best practice in relation to the MCA and DoLS and takes action to ensure this is consistently applied.

People told us they were generally happy with the variety and quality of food available. Their comments included, "You get plenty. They make a list of what you want every day" and "You get a good dinner here." The relative of one person who had a special diet told us that staff tried hard to cater for their needs and always aimed to give them a varied diet. Staff told us people were offered a choice of meals and we saw that people's food likes and dislikes were recorded in their care files. Food and fluid intake was recorded for those at nutritional risk, and people's weight was monitored. On the first day of our inspection we did, however, note that some improvement was required with the mealtime experience and the consistency of staff approach. People were served individually so some people had to wait at the dining tables whilst others were eating. The meal was a pork chop with vegetables, and the chops were over-cooked, so a number of people could not eat them or picked them up to eat them with their hands. The staff member present did not appear to notice that some people were having difficulty. Another staff member who came along part way through the meal noticed this straightaway and offered people assistance to chop the meat. Two people found it difficult to sit still to eat their meals and this was managed well by staff. Food was prepared in such a way for one person so that they could eat whilst walking and the other person received encouragement throughout their meal to remain seated. This worked well for them and enabled them to finish their whole meal.

The registered provider ensured that people who used the service were able to access appropriate health care professionals and receive treatment and support for their medical conditions. We saw evidence in care files that people had received support from other healthcare professionals, such as GPs, the district nurse, opticians and occupational therapists. Care files contained care plans in relation to people's mental health

and well-being and their physical health. For instance, one care file we reviewed showed that the registered provider had sought guidance from the GP and speech and language therapy team when they had identified a risk of aspiration for one person. There was also detailed information in relation to the support received from the district nursing team in relation to the person's skin integrity and pressure care. One person told us, "They get me the doctor if I need one. If I need to go to the hospital they always get an ambulance for me."

Good

Is the service caring?

Our findings

People who used the service spoke positively about staff, describing them as kind and caring. Comments included, "I love it, it's lovely. I like the people; the staff, mainly the staff," "We've had a few laughs (with staff)," "They (staff) know about my family, they know about my wife," "I like everything about it here. Most of the staff are terrific." Relatives told us, "The staff are caring. They seem nice" and "They (staff) try, and we are happy with what we see."

Staff we spoke with were able to demonstrate a good understanding of people's needs and preferences, and we saw that staff took opportunities to chat to people when they had chance. In our discussions with staff they demonstrated a caring approach towards the people they supported and one told us, "Staff care about people; we try to make it like a home from home." Another member of staff said, "All the staff are caring and if they don't understand something they'll ask. Our residents come first. For instance, one day one of the residents wasn't well so they called me and I went into hospital with them. We don't want people going on their own because it's very confusing for people. Staff will come in on their days off to take people out for the day. They will get paid for it, but they are still giving their day up, and they are happy to do it because they know people will enjoy it."

We made observations throughout our inspection of staff interacting with people who used the service. We saw examples of positive, warm and friendly interactions. We saw staff supporting one person when they were anxious and tearful. Staff clearly knew the person well, and sat with them and reassured them until they were more settled. They offered the person a cup of tea and some scrambled eggs on toast, which they agreed to and enjoyed. We observed staff chatting with people about topics of interest to the person, such as family members and television programmes. We also observed that staff responded calmly and appropriately when certain people became agitated and aggressive in their manner. Staff were able to use distraction and reassurance to diffuse situations and help people to feel less anxious.

We observed staff involving people in decisions, such as what they wanted to eat, and these choices were respected. We saw examples in care files of instructions for staff on how best to encourage and support people with decision making. For instance, one care plan we viewed stated the person was best able to understand and make decisions when they were in a happy mood, and prompted staff on how to support them with day to day decisions.

At the time of our inspection nobody who used the service had an advocate, but we were told that information about advocacy services was available to people. Advocates provide independent support to help ensure that people's views and preferences are heard.

Staff respected people's privacy. For instance, people told us, and we observed, that staff knocked on people's doors before they entered their rooms. Staff described to us how they provided personal care in a manner that maintained people's privacy and dignity. They also gave us examples of how they encouraged people to do as much as possible for themselves in order to maintain people's independence.

During our inspection we noted that people were weighed in a communal area. Whilst nobody objected to this, this practice did not promote people's dignity. The registered manager agreed to discuss this with staff in order to find an alternative arrangement.

The registered provider had an equal opportunities policy. Care files contained care plans in relation to people's social inclusion and relationships, and staff were able to give us examples of how they supported people with specific needs in relation to equality and diversity. Monthly church services were held at the home for those who wished to join in.

People were able to have visitors when they wished, and relatives told us they were made to feel welcome. Some relatives visited on a daily basis.

Requires Improvement

Is the service responsive?

Our findings

The registered provider completed an assessment prior to each person moving into the home, in order to ensure the service could meet their needs. A care plan was then developed by the registered provider in order to guide staff on how support the person. We found that care plans contained information about what people liked and disliked. Files contained care plan sections in relation to a range of areas according to people's needs, including mental health and well-being, physical health and well-being, medication, finances, nutrition, continence, personal hygiene, mobility, relationships and falls. Some individuals could present with anxieties and behaviours that challenged the staff and others who lived at the home. Where this was the case, care files contained challenging behaviour care plans which gave staff some guidance on how to respond and manage these behaviours. Some of these required more detail in order to be sure that staff knew how to respond consistently. For instance, one care plan we reviewed advised staff to use distraction techniques, but more detail about the specific physical and verbal distraction that may help to alleviate the person's distress would be beneficial for staff.

The registered provider's policy was to review care plans monthly and update them where required. We found that one file we reviewed was up to date, because the person had only moved in to the home the month before. Another care file had yet to be fully completed because the person had moved into the home three days before our inspection. A third care file had not been reviewed since December 2016. This meant it had not been updated to reflect a number of falls the person had recently had. This showed that not all care files had been consistently reviewed in order to ensure that they were reflective of people's current needs.

Staff completed monitoring records in relation to specific requirements, such as repositioning and food and fluid intake, where this was relevant to individuals. Monitoring and handover records completed for people also enabled senior staff to monitor that the care provided was responsive to people's needs and in line with their care plan.

Most relatives felt that staff were responsive to people's needs and kept them informed of any changes. Their comments included, "They (staff) let me know of any changes and if they are unwell or anything. They're very good" and "They know people's needs." One relative told us that staff were generally very good, but when busy "It's just the little things they sometimes don't notice, like ensuring people have a towel in their room."

During our inspection we saw limited evidence that people were supported to take part in activities and leisure opportunities of their choice. On the first day of our inspection we observed that staff played dominoes with a group of four people for about 20 minutes. The television was on for most of the day, and some people watched this periodically. There was also some social chat as a group, between people who used the service and with staff. There was a list of daily activities on the wall in the lounge area. The listed activity for that day was therapeutic colouring and a visit from the hairdresser but we did not see evidence of either. Staff told us the activity board was illustrative and that things on the day usually varied from the activity on the board. On the second day of our inspection a visitor encouraged people to join in some singing and dancing for a short period.

People told us, "There are no activities. I asked about board games but they said they didn't have any" and "We've had no outings so far but we are going to Bridlington for fish and chips, next month I think." Other people told us, "I spend my day in my room. They are always asking me to join in but I don't want to bother" and "I spend my day in here (bedroom). I've been to the lounge but there's nothing going on in there." A relative told us, "I see to [my relative's] entertainment. They don't seem to have any activities here." There was also concern from one relative that there was a lack of space for people to walk around the home and grounds, in order to promote people's exercise and mobility.

Feedback we received about staffing levels, and our own observations, indicated that staffing levels did not allow for significant amounts of time for individual social attention from staff, apart from for those people who were funded for one to one support from staff. However, staff did chat to people on an individual basis when they had chance. Staff told us that a singer visited the home monthly to provide entertainment, a hairdresser visited weekly and staff painted people's nails. The registered provider had purchased some additional land next to the current back garden in order to increase the space for people to walk around outside. They had also provided equipment and plants for one family who wished to be involved in developing the garden and flower beds with people. The deputy manager told us they were keen to develop more activities at the home, and we saw minutes of residents meetings which showed that ideas for activities and trips out had been discussed. The registered manager told us that three activities co-ordinators and a therapist had been employed across the three Hornsea services, and that one of these would soon be based at Spring House three days a week. Whilst some activities were available, it was evident from the feedback we received, and our observations, that there was opportunity to develop the range and variety of activity and entertainment.

We recommend the registered provider develops the range of activities, in line with people's individual interests and with regard to best practice in engaging people with dementia, in order to create a more stimulating environment.

The registered provider had a complaints policy and procedure, which was available to people and relatives. There was no record of any complaints received by the service, and the registered manager told us they had received no formal complaints. Some relatives told us they had raised minor concerns and suggestions and we were aware that some concerns had been raised by visiting healthcare professionals. Relatives told us that staff had responded to their concerns. People we spoke with said that they would talk with the registered manager or staff if they had any complaints, and felt confident that any concerns would be dealt with.

Nobody we spoke with could recall taking part in residents meetings, but we saw records that showed some residents meetings had taken place. Where people were not able to contribute to the meeting verbally, views and preferences had been recorded on their behalf. People told us, "There's never been any meetings but I would be happy to raise any concerns I may have" and "There's nothing I'd change here." Relatives told us, "I'm able to raise concerns" and "I speak to the staff with any concerns. They usually take things on board. Things are getting better for [my relative's] needs, but it's not there yet. I'm happy with the communication."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. They had been registered with the Commission as the manager of the service since December 2016. They were also the registered manager for another location and had area management responsibility for a third local service, run by the same registered provider. They split their time between the homes. In addition to the registered manager, there was also a care manager and deputy manager who provided day to day support and leadership to staff at Spring House. The new deputy manager had been in post for five weeks, and had begun implementing new systems and developing care plans for people who had recently moved to the home.

We spoke with staff about the management and leadership of the service and the support provided to staff. They told us the management was "Okay. They do their best for people" and "It's fine. You can go to [registered manager] with anything, or if you don't want to speak to him you can also speak to [care manager] or [deputy manager]. But [registered manager] is very good and approachable." One relative told us the 'day to day managers' (care manager and deputy manager) were good but said the registered manager did not always get back to them about things they had asked about.

Staff received support and guidance but there was a lack of records in relation to recent supervision meetings. There were records of regular staff meetings, which showed staff had received guidance and reminders about various topics, including documentation, people's individual support requirements, laundry and cleaning tasks.

When we spoke with staff about the culture at the home and values of the organisation they told us, "They value the staff. They take into account that you've got a home life. They value the job you do and the residents. I'm proud of this home; it's a nice home and the staff work as a team." Another staff member also confirmed, "We all work well as a team."

There was a quality assurance system in place, which involved a range of audits. There was a monthly 'workplace inspection' which assessed the environment, along with monthly first aid kit checks, and accident reviews to monitor accidents and falls at the service. There were also checks on policies and procedures and food hygiene self-assessments.

Audits of some care plans had been completed. We discussed with the registered manager the issues we identified in relation to some of the care files and risk assessments not being up to date. The registered manager told us that all care files should have been audited and they would ensure this was done, and that any issues identified in care plans would be addressed. We also found that medication audits had not been regularly completed prior to our inspection; there had only been two since November 2016. This meant that improvements required to medication practices had not been identified until recently and had yet to be addressed. Some actions identified in recent workplace inspections, such as an issue with the staircase flooring and inappropriate items being stored in the laundry, had not been addressed promptly in the week between the workplace inspection and our visit.

The registered provider was already aware of, and had clear plans to address, some of the issues we identified in our inspection, such as laundry facilities, increases to staffing levels, additional outdoor space and storage. However, other issues we identified in our inspection, such as MCA understanding and DoLS applications, the lack of recent supervision records and the improvements required to accident and incident reporting had not been identified through quality assurance processes. We had also not received a statutory notification, as required by law, in relation to the DoLS authorisation that was already in place for one person. We will address this with the registered provider outside of this inspection process.

Collectively this showed that improvement was required to governance systems and record keeping. This was a breach of Regulation 17 (2)(a)(c) of the 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 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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure there were adequate systems for the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to consistently assess, monitor and improve the quality and safety of the services provided.