DRB Healthcare Limited

Springfield Park Nursing Home

Inspection report

Springfield Park
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Tel: 01706646333

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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

Springfield Park Nursing Home is a large detached building that is situated in parkland. The home provides both nursing and personal care for up to 70 people. There were 61 people accommodated at the home on the days of the inspection.

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first rated inspection for this home because there was a new provider who first registered with the Care Quality Commission in November 2016.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and did not contain any offensive odours. The environment was maintained at a good level and homely in character.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were encouraged to eat and drink to ensure they were hydrated and well fed. The service provided one choice of main meal with other alternatives such as sandwiches or baked potatoes. The registered manager said they would look at providing an alternative main meal.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of her responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

Some staff had been trained in end of life care which should enable them to provide support to people who used the service and their family at the end of their life.

Activities were provided which were suitable to the age and gender of people who used the service.

Audits, quality assurance surveys and meetings helped the service analyse performance to help improve the service.

There was a suitable complaints procedure for people to raise any concerns.

Staff and people who used the service said the home was well-led and the manager was approachable. This view was not shared by two relatives.

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.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

There was a redecoration programme to improve the environment.

Is the service caring?

Good

The service was caring.

We observed and were told staff were kind and caring.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

We saw that people were offered choice in many aspects of their lives.

Is the service responsive?

Good

The service was responsive.
There was a suitable complaints procedure for people to voice their concerns. The manager of the home responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

People's views were recorded in surveys and the service responded to what they said.

Springfield Park 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 was unannounced on the 10 October 2017 and was conducted by one adult social care inspector and an Expert by Experience. An adult social care inspector concluded the inspection on 11 October 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia.

We requested a provider information return which was returned to us in a timely. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used the information the service provided to help plan the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also asked the local authority and Healthwatch Rochdale for any information they held on the service.

We spoke with three people who used the service in depth, eight people who used the service who had limited responses, four relatives, the registered manager, deputy manager, the cook and four care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care and medicines administration records for twelve people who used the service. We also looked at

the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

The people who used the service indicated or answered that they felt safe. One person commented, "The staff have looked after me they are all very nice people." One visitor did not think there were sufficient numbers of staff trained to look after their family members specific needs, which could possibly lead to unsafe care. We spoke to the manager about this who said they accessed training for any specific needs people used the service had. They had access to professionals in other organisations they could go to for help, advice and training.

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy. A whistle blowing policy allows staff to report genuine concerns with no recriminations. The local authority told us there had been three recent safeguarding concerns. They told us there had been three recent issues raised which were being investigated and the service were assisting them. We spoke with the relative of one person who had been involved in a safeguarding referral. The person said, "I'm very grateful for the way the registered manager dealt with it. She has been totally supportive throughout."

The staff we spoke with were aware of safeguarding issues and made comments such as, "I am aware of the whistle blowing policy. I would report any issues I saw. I gave a care staff member advice at another home. I think they would deal with any issues"; "I have not had to whistle blow but I would report any abuse. I think I would be listened to and supported if I reported abuse"; "I know about the whistle blowing policy. I have had to report poor practice. I was listened to and action was taken" and "I am aware of the whistle blowing policy. It is something we are taught straight away. I have had to report an abuse issue. You not afraid to report abuse." The deputy manager said, "I am aware of the whistle blowing policy. It is kept confidential here to protect staff. I would definitely deal with poor practice or abuse. I had to dismiss a person for poor attitude." Staff were aware of and prepared to use the policy to help keep people safe.

We asked people if they thought there were enough staff on duty. One person who used the service said, "I can't get a drink when they are short staffed, it's hard to find them. They will say I'll just be a minute but don't come back. It's not their fault they are very busy." A relative told us, "They are very busy at meal times. It's difficult if he needs the toilet but on the whole they keep him clean but they are very busy. Carers are very good but they are run ragged." Staff said, "There are enough staff here to meet people's needs"; "We can be short but not often and that is staff calling in sick" and "We have been short staffed lately. They are recruiting but the gap until new staff start makes it more difficult." We were aware that two members of staff had recently been dismissed for misconduct and an outbreak of scabies had caused further staff shortages because they were unable to work. However, staff involved in the outbreak were now able to return to work and new staff were being recruited to replace those dismissed. On the days of the inspection we noted call bells were answered promptly and staff had time to talk to people who used the service although they were busy.

The registered manager said she used a dependency tool for determining the numbers of staff and the home was currently running on staff numbers for 70 people. We looked at several weeks duty rota and saw that there was a consistent staff team except where there had been an outbreak that was contagious. The deputy manager said it had been difficult to staff at this time because some staff were not able to attend work. We did see a new staff member attending the home to go through an induction, which showed staff were being replaced.

On the days of the inspection staff on duty included the registered manager, deputy manager, three registered nurses in the morning and two on the later shift, seven domestics (although this dropped to four at weekend), two senior care staff all day, ten care staff in the morning and seven on the late shift, the cook and kitchen assistant, an activities coordinator, a maintenance person, three decorators and an administrative assistant. From the rotas we looked at this was around the average every day.

We looked at four staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

The service checked the registered nurses remained on the register of the Nursing and Midwifery Council which is a requirement for them to practice.

We looked at four plans of care during the inspection. We saw each plan of care contained a risk assessment for falls, moving and handling, tissue viability and nutrition. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service. We saw that where necessary professionals we called in to provide information and guidance. The registered manager and area manager conducted regular audits to ensure the environment was safe, including possible hazards which could cause slips, trips and falls.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

We saw that the electrical and gas installation and equipment had been serviced. There were other certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), hoists, the lift, the nurse call and fire alarm systems. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits.

Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the fire procedures. Fire extinguishers had been maintained. In the plans of care each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in the care plans and near the entrance in a 'grab bag' so staff could get hold of them in an emergency to present to the fire brigade. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a gas or power failure.

On the first day of the inspection we toured the building. The home was clean, warm and did not contain any offensive odours. A relative told us, "The home is cleaner now they have employed another domestic."

The registered manager said cleanliness had improved since a housekeeper had been employed who was responsible for the overall cleanliness of the home.

There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. Staff we spoke with confirmed they had undertaken infection control training. Domestic staff had instructions on what to clean and how often which was checked by the housekeeper. This included deep cleaning of rooms on a rotational basis. We saw the records the service kept which showed when cleaning had been completed and by which member of staff.

There was a laundry sited away from any food preparation areas. The laundry contained sufficient equipment to help keep people's clothes clean and presentable. Washing machines had a sluicing facility. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment (PPE) such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used this equipment when they needed to.

We looked at how the service administered medicines. We observed a member of staff administering medicines and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. There was also a copy of the national institute of clinical excellence (NICE) medicines guidelines for staff to refer to. This is considered to be best practice guidance for the administration of medicines. All staff who supported people to take their medicines had been trained to do so and had their competency checked to ensure they continued to safely administer medicines.

We looked at ten medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home which helped staff check the numbers of medicines people had. There was a photograph on each MAR to help staff identify the correct person.

Medicines were stored in locked trolleys chained to the wall within a locked room. Medicines were stored separately from other clinical supplies and supplements. The temperature of the medicines room was checked daily as was the medicines fridge to ensure medicines were stored to manufacturer's guidelines. We saw from the records the temperatures were within the recommended range.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

We saw that topical medicines such as ointments were recorded in the MAR. The service used body maps to show staff where to apply the medicines.

Food supplements were given by trained staff and recorded in the MAR charts. We saw the medicines system was fully audited monthly with random checks in between to check for any errors. Staff retained patient information leaflets for medicines and also a copy of the British National Formulary to check for information such as side effects.

Good

Is the service effective?

Our findings

We asked people who used the service what they thought about the meals served at the home. People who used the service said, "The food is quite nice"; "It's OK"; "It's alright" and "Sometimes the meals are very good, sometimes I send it back then it's sandwiches or nothing." A relative said, "Since the new company took over the food is not as good. The variety is not the same."

We did see that whilst there was only one main choice of meal there were several alternatives such as sandwiches, omelettes, salads and baked potatoes. We discussed the lack of choice of the main meal with the registered and deputy managers who both agreed they would look into the possibility of offering two main meal choices at each serving as well as the other alternatives. This would give people more options.

People were offered the usual breakfast foods, for example, cereals and toast and a cooked option if they wished. We sat in one of the dining rooms during the inspection and the four people we observed were satisfied with their meal which was hot and looked nutritious. People spoke with each other and enjoyed the social atmosphere. Staff were observed to have a good rapport with people and asked them what they wanted. One person had a salad instead of the main meal.

Most tables were set with tablecloths and cutlery. Condiments were available for people to flavour their foods. There was a choice of hot or cold drinks. The few tables which were not set as invitingly as the others were because (we were told) a person removed everything and it was not safe to have sharp objects and unhygienic to have the cutlery touched.

During mealtimes we observed people could sit where they wished. Most sat in the dining area but we also saw people took their meals in their rooms. We spoke with the cook who told us, "I go and ask people what they like to eat and attend meetings, which usually include food related items. We put on a full English breakfast and because of what they said we have provided more salads and lamb steaks. People asked for lamb chops but we could not provide them because of the risk of choking on the bones so we provided lamb steaks instead. We offer options, besides the main meal people can have sandwiches, omelettes, salads, curries, what they like really."

Meals were recorded to ensure an audit trail could be followed if there were any problems. The cook also said she had allergen advice and although most food was freshly prepared would check any allergy advice from pre-packaged products which should mean people did not eat food which could be harmful to them. The kitchen was rated as five stars, very good from the last environmental health inspection which meant food ordering, storage, preparation and serving were safe. We went into the kitchen and found it to be clean and tidy. We saw there was a good supply of fresh, frozen, dried and canned foods. This included fresh fruit which was made available daily from the drinks trolley.

The cook was notified if anybody required any special diets or needed to have their drinks thickened which was undertaken by care staff. We saw people had access to a speech and language therapist (SALT) or dietician for advice, which included enteral feeding. Training was also provided by these professionals if

required for people needing to be PEG fed, which is feeding through a tube. People's weights were recorded to ensure staff were aware if people were gaining or losing too much weight.

We toured the building during the inspection and visited all communal areas, several bedrooms and the bathrooms. The home was clean, tidy and fresh smelling. There was equipment to aid people with their mobility needs and staff had been trained to use it.

We saw that the new provider was updating the home by decorating many of the communal areas and was a work in progress with staff decorating the home during the inspection. There were several lounges and dining areas, including quiet smaller lounges where people could visit or sit in if they wished. One lounge was set up for relatives to stay in should their family member be ill. There were also new tables, chairs and flooring. This helped to improve the environment but also retained a homely atmosphere.

We visited many bedrooms and saw they were comfortable and many personalised to people's own tastes. There were garden areas for people to use in good weather with seating and tables. There was a lift to ensure people were able to reach both floors.

There were baths and wet rooms for people to choose their preferred method of keeping clean. Baths had aids for people with mobility problems to bathe safely.

We saw from looking at the plans of care that people had access to professionals and specialists. This included hospital appointments and routine visits by opticians and podiatrists. This meant people's health needs were kept up to date. People also had their own GP.

Incidents and accidents were recorded and investigated. The records showed us what action the service had taken and what they did to try to prevent any further accidents such as ordering pressure mats which let staff know when people are moving in their rooms and updating care plans.

We saw from the plans of care that people, where possible, gave their consent to care and treatment and we also saw staff asking for people's consent before they attempted to assist them with their personal care needs. We saw that consent was gained for people to be photographed, who was agreed to have access to the plans of care, if a person wanted to vote and who controlled pocket money. We saw that where a person lacked consent this was done on their behalf after a best interest meeting. This ensured people received what they wanted in the least restrictive way.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005).

We saw evidence in the plans of care that people who did not have mental capacity had an assessment and were referred to the local authority using the current guidance. This meant people were assessed independently and a DoLS authorised if needed. There were 23 people accommodated at the home who required a DoLS authorisation, which had been reported as required to the Care Quality Commission. People's mental capacity was regularly assessed to ensure any previous assessment remained valid.

When new staff commenced working at this care home they have an induction. The induction included a tour of the building, some of the rules for working at the home, key policies and procedures, the fire procedures, supervision and appraisal and safeguarding. Staff were then enrolled on the care certificate which is considered to be best practice for people new to the care industry. There were five staff who had just completed the care certificate and we saw a new member of staff on one day of the inspection completing part of the induction process.

Staff told us, "I think the training is quite enough. I completed all the mandatory training and have a diploma in health and social care"; "I think we complete enough training to do the job"; "I think I am competent in my role. If not I would ask for more training. I would go to the manager or deputy if I needed more information"; "I think I am over trained to be honest" and "I have done all the mandatory training. I have also completed the end of life passport and have a diploma in management and leadership. We also have training for the care of people with dementia, tissue viability and epilepsy. We get training to use the various machines such as for PEG feeding. We get trained as needed for specialised equipment. All nursing staff are ventilator trained. Some care staff are as well. The training Is second to none and I have been encouraged to learn so now I feel confident."

We saw from looking at the training matrix, staff files and talking to staff that training was ongoing. Training included the MCA, DoLS, first aid, fire safety, food safety, nutrition, medicines administration, moving and handling, infection control, health and safety, safeguarding, the care of people with behaviours that may challenge others and fire awareness. Staff were encouraged to complete further health and social care training such as a diploma or NVQ, end of life training and the care of people who have a dementia.

One relative told us she did not have confidence staff were suitably trained in the use of specific equipment. We spoke to the deputy manager who told us, "Tracheotomy training for the nurses is in house by the two managers who have both been trained at the local hospital. For enteral feeding a dietician comes in and trains us and the competent staff train others. Syringe drivers are part of the nurse training and Springhill hospice will train staff and visit the home to check staff are competent. Pharmacy will get involved and teach staff about the drugs and remain involved for advice. All staff are catheterisation trained. Competencies in all the clinical areas are checked every now and again. One member of staff was undergoing a prearranged competency check during the inspection.

Staff told us, "I get supervision or regular 1 – 1's and appraisals twice a year. It is a two way process and staff can discuss any training they want. Nursing staff are encouraged to complete their revalidation and given help to complete it"; "We get appraisals and supervisions and I can discuss my training needs. They are always asking if we need extra training", "I have just had an appraisal and supervision. I got the chance to discuss my career and if I wanted any other support", "If I did not think I had done enough training you can say so at supervision and appraisal. I have regular supervision" and "I get supervision and appraisal. I have had quite a few this year. It is a two way process."

Good

Is the service caring?

Our findings

People who used the service told us, "It has taken a while but is like a new lease of life, they got me an electric chair and have helped me so much I want to get into my own house again"; "The staff are very good", "It is a good place and I love living here" and "The girls are lovely". A relative said, "The nurses are brilliant, [named the head nurse] is amazing with us and my brother." All the people we spoke with either said or indicated they felt well cared for by staff.

Staff we spoke with said, "I like caring and enjoy the job. If not I would quit it. I would prefer to look after a family member at home but it would be all right if they lived here if we could not look after them", "The care is fantastic. I think we do to the best of our abilities. I would not mind a family being cared for here. The residents seem to like it. I am happy giving care and looking after people"; "I have done care from a young age and wanted to ensure people were well cared for. I do it because I care and enjoy looking after people. I would be happy for a member of my family to be cared for here" and "I started this year's job ago. I wanted to provide better safer care than what seemed to be the case and prove to myself we can really care for people."

In the plans of care we saw there was a good background history of each person. This included people's likes and dislikes, hobbies and interests. The information enabled staff to treat people as individuals. One person told us their independence had been helped by staff assisting them to get an electric wheelchair. We saw that staff knew people by their preferred names which showed staff knew them well. We also saw that people went out independently of staff to the local park or shopping.

People were able to choose what they wanted to do such join in activities, the times they got up or went to bed and where they preferred to sit during the day. Some people chose the lounges, to go out in the garden area or remain in their rooms. We observed staff offering people choice in what they did or, for example, what drink or meal they wanted.

We saw that staff were taught about confidentiality topics, had confidentiality policies to support their practice and that records were stored securely so only allow people who needed access to the documents were able to do so.

We observed staff at various times during the inspection. We did not see any breaches of privacy which helped protect the dignity of people who used the service.

The cook attended meetings with people who used the service to see what people liked to eat and amended the menu accordingly.

We did not see anyone being treated disrespectfully. We were told that a staff member who had been rude and disrespectful to people in the past had been dismissed. This was appreciated by people who used the service.

Visiting was unrestricted and people could take visitors in the communal areas or quiet areas or their rooms if they wished privacy. People who used the service were encouraged to remain in contact with their family and friends.

Five staff had completed end of life training with the local hospice which is considered to be best practice in Rochdale. A further eight staff were due to start the course. This training equips staff with the skills to care for people and their families at the end of their lives. We saw that following the training a room had been designated as a quiet room where families or visitors could stay for as long as they wishes if a person was ill. There were refreshment facilities and comfortable seating people could use to sleep over if they wished. The service had also invested in a music system which played soothing music in a person's room if they wished and sensory equipment to help relax people.

Although not everyone had good end of life wishes recorded in their plans of care we saw that this was a work in progress since the training and some had good details. Recording a person's end of life wishes helps ensure that people get the treatment they want at the end of their life and staff also have the necessary details to support families if they pass away.

People were able to attend a religious service and take communion if this was their preferred way of following their religion. This was an interdenominational service for people of all faiths. The registered manager said specific clergy attended at request for people with specific religious needs such as for last rites.

We saw there were many thank you cards from relatives. Comments included "Good care and affection" and "Every kindness was shown to us all and we are really appreciative, you all do an amazing job."

Good

Is the service responsive?

Our findings

There was a suitable complaints procedure accessible to people who used the service and their relatives. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission.

People either told us or communicated to us they contact the registered manager or deputy manager if they had any concerns. Two relatives told us they had raised concerns and did not feel they had confidence they would be dealt with effectively. Two relatives and one person who used the service had raised concerns and felt they had been listened to and action had been taken. One of the concerns this family member raised was from over a year ago and we had confidence the registered manager had answered it to the best of her knowledge. We looked at the complaints folder which showed the registered manager had responded to all six of the concerns. For example a relative complained about the laundry. This was investigated and brought up at staff meetings to rectify the problem. One was about the attitude of a staff member and disciplinary action was taken. The responses were within the policies timescales.

The deputy manager said, "The registered manager tries to work through any complaints but some people cannot accept we work for the person who lives here, which is not always what the families want." We discussed this with the registered manager and asked if they thought an advocate may be useful in this situation. An advocate will act independently of staff or family to try to get the best outcome for people who use the service. The registered manager said she would try to arrange an advocate for one person but the other person was going through the court of protection to protect their best interests.

We looked at four plans of care during the inspection. Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. We saw that the assessments had been fully completed for each person. This process helped to ensure that people's individual needs could be met at the home.

The plans of care showed what level of support people needed and how staff should support them. Each heading, for example personal care, tissue viability, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. The plans were reviewed regularly to keep staff up to date with people's needs. The quality of care plans was regularly audited by management. There was a daily record of what people who used the service had done or how they had been to keep staff up to date with information.

A relative told us, "The hand overs are not good they don't pass information on from one shift to another." We asked staff about the handover process. Staff said, "There is a handover at the beginning of a shift. They

last about 20 minutes. Passing on any care information and if people have an appointment" and "I attend daily handover, twice a day so there is no missed communication or how people are. I fill in the handover sheets." We saw that staff did have a handover and information was recorded to ensure all staff knew what was happening with people's care needs.

There was a series of planned activities at the care home. There were two staff members purely to provide activities and entertainment. One of the activities coordinators was on annual leave at the time of the inspection. Besides the planned activities we saw people were able to go out independently to do their shopping, go out for a cigarette or for trip around the local park. We also saw people using the garden area. Springfield is situated in one of Rochdale's parks. There were also two work experience students assisting with activities. One person who was not able to go out independently did say they would like to go out in the park more often.

One interest was feeding the birds and squirrels in the garden. Other activities on offer included arts and crafts, pamper sessions, quizzes, baking, life skills, different games, library packs for reminiscence therapy, coffee mornings and food tasting. One person was taken to football matches, people went shopping, outings were arranged to places of interest, trips arranged to the local pub or to the park. The service held an annual summer fair. Once a year the service held a remembrance day for relatives if they have lost a family member. There was a service or reading, and then they commemorated the event by releasing balloons and having refreshments. There was a diners club. People chose the menu and it was held like a restaurant experience. Some people attended clubs and societies.

The hairdresser visited weekly, external entertainers came into the home, people went out with their families and a reflexologist was also available if people wanted to use the service. The activities coordinators held one to one sessions with people who had a dementia or did not wish to attend group activities. Birthdays were also celebrated as was special days such as Easter and Christmas.

Good

Is the service well-led?

Our findings

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people who used the service if they thought the service was well-led. People said they felt they could go to the registered manager. We observed the registered manager knew all the people who used the service by name and people felt comfortable in her presence. Two relatives did not have a good rapport with the registered manager. Another person we spoke with said, "I'm very grateful for the way the manager dealt with [issue involving alleged assault]. She has been totally supportive throughout." We saw several visitors going in and out of the office and they appeared to have a good relationship with the registered manager. A comment from a visiting professional told us, "It is a pleasure to come into the home and the registered manager knows what she is doing. How improved [our relative] is and the care plans are excellent."

Staff told us, "Some of the managers are very supportive. I have not any problems. You can go to the registered manager. She is available to talk to"; "I can go to any of the managers for support and advice. The manager's door is always open and she is approachable"; "The manager is brilliant. A couple of family members are quite abusive towards her but she is always professional. The manager has helped me a lot and is always there to talk to and gives good advice", "I think there is a good staff team. There is a good atmosphere at the moment and everyone is motivated. The manager is really good" and "I love the manager – she is the nicest manager I have ever worked for and encouraged me to improve. She is firm but fair and makes sure everything is done but also very approachable. You can phone her at any time."

We looked at some policies and procedures which included key ones, for example, confidentiality, DoLS, dignity and privacy, duty of candour, health and safety, infection prevention and control, mental capacity, safeguarding, the safe use of social media, whistle blowing, data protection and how to manage aggression and difficult behaviour. We saw the policies and procedures were updated and available for staff to follow good practice.

A statement of purpose was available to inform professionals of the registration details of the service, key staff and their contact details, the range of staff and qualifications, the organisational structure, aims and objectives, the facilities and services offered and the complaints procedure. There was also a service user guide which also informed people who used the service the full range of what the service provided, how to complain if people wished, the facilities on offer, service user involvement, meals and mealtimes and what was included in the fees or people had to pay for. These documents helped people make an informed to choice to stay at Springfield Park Nursing Home.

During our inspection our checks confirmed the provider was meeting our requirements to display their most recent CQC rating.

The manager conducted regular audits. These included call bell response times, medicines, health and safety, plans of care, catering quality, infection control including cleanliness, people's experience of the home, hand hygiene, the environment which included hazards and equipment checks such as mattresses. The area manager also conducted monthly visits and audited supervisions and appraisals, the environment, health and safety, any maintenance issues, plans of care, CQC compliance, occupancy levels, staffing, DoLS, safeguarding issues and results of investigations, accidents, new staff, and activities. We could see from the audits that where a fault or shortfall was detected this was written into an action plan and followed up. A plan was completed for any shortfalls in the service and action taken to improve the service. We saw this included new kitchen equipment, new patio doors, redecoration and ensured any gaps in training or supervision were identified. The audits were used to help improve the service.

There were regular staff meetings. At the last staff meeting of October 2017 topics on the agenda included discussed outbreak of disease response, training, thickening of food and fluids, completing records correctly, maintaining confidentiality, making sure people were assisted to bed in the right clothing, reporting falls, infection control and new staff. Staff were able to have a say in how the service was run by being given a chance to speak at meetings.

The service sent out annual quality assurance questionnaires. The last surveys were completed between May and September 2017. The results were mainly positive. However, where the results were not as positive we saw action had been taken to try to improve the service. For example, people wanted a mirror in a dining room and this was provided. A comments book had been placed in each dining room so people could report on the quality and choice of food and a toilet had a hand rail fitted at people's request. This showed the service responded to what people wanted.