Mrs D Hudson

Spring Bank Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected Spring Bank Nursing Home on 11 November 2014. The inspection was unannounced. There were 17 people living in the home at the time of the inspection.

Spring Bank Nursing Home provides accommodation for up to 31 people, predominantly older people. It is situated in the area of Silsden, which is on the outskirts of Keighley. The accommodation is on two floors and there is a passenger lift. The home is set in its own grounds and there is parking by the side of the building. There are single and shared bedrooms.

The last inspection was on 12 June 2014 and at that time we found the provider was not meeting a number of the regulations. We told the provider they must take action to make improvements in care and welfare, nutrition and assessing and monitoring the quality of the service. We also gave them a warning notice telling them they must take action to improve the training and support provided to staff. We followed up all those areas during this inspection.

The service has not had a registered manager since November 2013. A registered manager is a person who

Summary of findings

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.

We found the service was lacking consistency and clear leadership. There was a lack of a structured approach to the management of the service. There were some systems in place to monitor the quality of the services provided but these were not working well.

The provider did not have effective systems in place to identify, assess and manage risks to the safety and welfare of people who used the service and others. The provider did not always take appropriate action when, other agencies such as the Commission, told them about risks to people's safety and welfare. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe and secure at the home. However, we found the provider did not always follow the correct procedures for reporting allegations or suspicions of abuse. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not managed safely. People did not always receive their medicines in the way they had been prescribed. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was clean and decorated and furnished to an acceptable standard. People's bedrooms were warm and comfortable. However, the building did not always meet the standards of safety and suitability set down in law. For example, a recent environmental health inspection had identified structural problems with the kitchen windows and the provider had failed to take action in a timely way to deal with this. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the numbers of staff on duty were adequate to ensure people's needs were met.

We saw that some staff training had taken place. However, there was no evidence of a planned and structured approach to providing staff with the training and support they needed to deliver safe and appropriate care. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living in the home told us they had enough to eat and drink and said they enjoyed the food. The records which related to supporting people to meet their dietary needs were not always available and/or accurate. This created a risk that people would not receive the right support. This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who lacked capacity were not always protected under the Mental Capacity Act 2005 and the service was not meeting Deprivation of Liberty Safeguards (DoLS). For example, one person's records stated they must not be allowed to go out of the home alone. There was no evidence to show the best interest decision making process had been followed and a DoLS application had not been made. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found people had access to the full range of NHS services. However, on occasions we found there had been delays in referring people to other health care professionals. This could result in delays in people receiving appropriate care or treatment.

The home had a warm and homely atmosphere. We saw staff were kind, caring and compassionate in their interactions with people. People looked clean and well cared for and were wearing appropriate clothing and footwear.

The majority of people we spoke with told us the staff were caring and looked after them well. However, two people told us some staff, and in particular the night staff, were not always kind and compassionate. We discussed this with the provider and manager. We spoke with two people's visitors and they told us they had no concerns about the care provided and confirmed they could visit at any time.

People's needs were assessed and the information was used to develop plans of care. We found the provider did

Summary of findings

not always support people to be involved in making decisions about the planning and delivery of care. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information about people's past lives, interests and preferences was recorded and we found staff knew about people's needs and preferences.

Information about planned activities was not displayed in the home which meant people might miss out because they were not aware of what was going on.

The majority of people told us they had no reason to complain but would not hesitate to talk to the management or staff if they had any concerns. We found some of the information in the complaints procedure was not correct. This could make it difficult for people to know what to do if they were not satisfied with the way the provider had dealt with their concerns. This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Inadequate

People told us they felt safe and secure at the home. However, we could not be assured that allegations or suspicions of abuse were always dealt with appropriately.

Medicines were not managed safely. People did not always receive their medicines in the way they had been prescribed. When people were not able to consent to taking their medicines the provider did not make sure the correct processes were followed.

The home was clean and decorated and furnished to an acceptable standard. However, the building did not always meet the standards of safety and suitability set down in law. When the provider was told about shortfalls they did not always act promptly to make sure people were protected from the risks associated with unsafe or unsuitable premises.

We found the numbers of staff on duty were adequate to ensure people's needs were met.

Is the service effective?
The service was not effective.

Inadequate

There was evidence that some staff training had taken place. However, there was no evidence of a planned and structured approach to providing staff with the training and support they needed to deliver safe and appropriate care.

People said there was plenty of food and they said they enjoyed it. We found people were offered a choice of food and drink. The records about supporting people to meet their dietary needs were not always accurate and this meant there was a risk of people's nutritional needs being overlooked.

People who lacked capacity were not always protected under the Mental Capacity Act 2005 and the service was not meeting Deprivation of Liberty Safeguards.

People had access to the full range of NHS services. However, referrals to health care professionals were not always made promptly. This could result in a delay in people getting the right support to meet their health care needs.

Is the service caring?
The service was caring.

Good

Summary of findings

The home had a warm and homely atmosphere. We saw staff were kind, caring and compassionate in their interactions with people. People looked clean and well cared for, they were wearing appropriate clothing and footwear. The bedrooms were clean and warm and most people had some personal belongings in their rooms.

The majority of people we spoke with said they felt well cared for, however, one person said they sometimes had to wait a long time for staff .

There were no restrictions on visiting. We spoke with two people's relatives and they told us they visited at different times and never had any concerns about the care.

The staff we spoke with were able to tell us how they ensured people's privacy and dignity was respected. We observed throughout the day people were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and there were care plans to show how people were supported to meet their needs. The care plans did not always have enough detail and people were not always involved in planning and reviewing their care. Information about people's past lives, interests and preferences was recorded.

There were some activities for people who lived in the home. Information about planned activities was not displayed in the home which meant people might not always know what was available.

Most people told us they had nothing to complain about and would not hesitate to speak to the management or staff if they had any concerns. Some of the information in the complaints procedure was not correct and this could make it difficult for people to take their complaint further if they were not satisfied with the provider's response.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager and there was a lack of consistency and leadership.

There was a lack of a structured approach to the management of the service. There were some systems in place to monitor the quality of the services provided but there were not working well

The provider did not have effective systems in place to identify, assess and manage risks to the safety and welfare of people who used the service and others. The provided did not always take appropriate action when, other agencies such as the Commission, told them about risks to people's safety and welfare.

Spring Bank Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 November 2014 and was unannounced.

The inspection team was made up of two inspectors, one of whom was a bank inspector, a specialist advisor in nutrition and an expert by experience. 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 the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams. Before our inspections we usually ask the provider to send us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider asked for an extension of the timescale and returned the PIR within the agreed revised timescale.

During the inspection we spoke with seven people who used the service and two people's relatives. We observed how people were cared for and supported in the lounges and we observed the meal service at lunch time. We looked around the building including a random selection of people's bedrooms, communal bathrooms and toilets and the lounges and dining room. We looked at seven people's care records, four to check how people were being supported to meet their nutritional needs and three to look at other aspects of people's care. We spoke with staff including a nurse, three care workers, the cook, the breakfast assistant, the manager and the provider. We looked at other records relating to the management of the home, these included training records, staff files, maintenance records and policies and procedures.

Inadequate

Is the service safe?

Our findings

Five people who lived in the home said they felt safe and secure in the home and were not worried or afraid of anything happening to them. They said the staff were gentle and considerate when handling them and were competent when using equipment such as the hoist when lowering people into the bath. One person said, "The staff are not awkward or clever, never brusque. I like it here." Another person said, "I'm not worried when I get bathed, the carers aren't awkward they tell me when I'm going over the top of the bath." A third person said, "I feel apprehensive when getting in the bath but there has never been an accident. I am not worried and feel alright living here."

Two people we spoke with expressed some concerns. They said some staff, particularly the staff on night duty, were not always attentive to their needs. One person said, "They don't treat me rough but could be a lot more thoughtful and careful. Some are awkward and bad tempered, they won't do this and that, especially at night." We discussed this with the provider and manager who said they would follow it up.

Following a visit to the home by Contract and Quality Assurance officers employed by the Local Authority in July 2014 we were informed about a safeguarding incident which had not been reported. A person who used the service had left the home unaccompanied and was missing for approximately 1.5 hours. The person was found by their relatives and did not come to any harm. However, the incident had not been reported to the police at the time the person was missing or subsequently to the local safeguarding team or the Commission. This demonstrated the service did not have appropriate arrangements in place to safeguard people who used the service.

The staff we spoke with during the inspection were aware of the different types of abuse and told us they would have no hesitation in reporting something if they suspected abuse. The new manager, who had taken up their post two weeks before the inspection, was aware of safeguarding procedures and the requirement to notify the Commission about any allegations or suspicions of abuse. In one person's care records we saw information about a recent incident which raised a safeguarding concern; this had been reported to the Local Authority safeguarding team and to CQC. We saw appropriate action had been taken to safeguard the people involved.

However, we could not be assured that the provider had suitable arrangements in place to identify the possibility of abuse and prevent it before it occurred and to respond appropriately to allegations of abuse.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we looked at the systems for the ordering, storage, administration and disposal of medicines. Medicines were stored securely in suitable trolleys and cabinets but the room in which they were stored was also used as the nurses' office and was not locked. The temperature of the medicines fridge was checked to make sure medicines were stored at the correct temperature.

We asked the nurse in charge if the service had a medication policy. They said it was probably in the office upstairs but said they had not seen it. We found the service had a medication policy which was not dated. There was also a copy of the NICE guidelines on the safe management of medicines which had been provided by a visiting health care professional in September 2014. The provider confirmed the NICE guidance had not been implemented.

We asked the nurse on duty if anyone was having their medication given covertly. They told us one person had their tablets crushed. The provider's medication policy stated, "The stability of medication may be altered by administering it in a covert way, e.g. in food, and so this should be checked with the pharmacist." There was no evidence this had been done. The person had a medicines care plan dated 3 July 2014 but it had no information about crushing their tablets. There was no evidence to demonstrate how this decision had been made and by whom and the records showed the person lacked capacity to consent to having their medicines given in this way.

In another person's records we saw a note which had been written by one of the nursing staff and was not dated. The note said the person's GP had said one of their medicines could be taken out of the capsule and sprinkled on to their food. The note said this was because the medicine was not available in liquid form. The course of medication started on 14 October 2014 and had been completed at the time of

the inspection. There was no documentation to show that consideration had been given to how this might alter the way the medicine worked or to show that the decision had been taken in the person's best interests.

When we looked at the medication administration records (MARs) we saw that when variable doses were prescribed the amount administered was not recorded. This meant it was not clear how much medicine the person was taking and it was impossible to maintain an accurate stock balance. We asked the nurse in charge who said in the case of Paracetamol people usually had two tablets, they said if someone just had one tablet they would record it.

In the fridge we saw two containers of eye ointment which had not been dated when they were opened. The instructions said they should be discarded four weeks after opening. This risked people receiving medicines which were no longer effective.

When we looked at the medicines classified as controlled drugs we found a discrepancy between the amount the records showed as being in stock and the number of actual tablets in stock. There was one tablet unaccounted for. We asked the provider to investigate this and let us know the outcome.

The nurse in charge told us they had done medication training but had not undertaken a competency assessment. They said the other nursing staff who also administered medicines had not had their competency assessed.

We looked at prescribed nutrition supplements and found they were stored appropriately in the medicines fridge. We observed staff who were giving out drinks using a thickening powder, Thick and Easy, in some people's drinks. The thickening powders were prescribed for named individuals but there were no specific instructions about the amount to use. The label said to use "as directed". When we asked staff they told us the added two scoops so that the drinks would not be too thick or too thin. There were no care plans in place to direct staff on the correct amount to use for each person. Therefore there was a risk the needs of people with swallowing difficulties were not being properly met.

This showed the provider did not have suitable arrangements in place to protect people from the risks associated with medicines**.** This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had undertaken environmental risk assessments. These covered all areas within the service.

The service had an emergency plan in place. However, this was incomplete as it did not identify transport methods or places of safety in the event of evacuation.

We saw certificates for servicing and maintenance of equipment and premises. This included the electrical wiring certificate which had not been available at the last inspection in June 2014.

The kitchens were inspected by the Local Authority environmental health department in September 2014. They were given a food safety rating of one (the lowest) out of five. In addition, an improvement notice was served in relation to required improvements to the structure of the kitchen. The environmental health officer contacted us in November 2014 to let us know they had gone back to check and found the structural work on the windows had not been done. They were following this up in line with their enforcement procedures. The environmental health officer told us they had not identified any major food hygiene risks but had concerns about the management of the service because action had not been taken in response to identified risks.

During our inspection in June 2014 the manager, who has since left the service, told us West Yorkshire Fire & Rescue Service had issued an improvement notice to the provider following a fire safety inspection. Before this inspection we contacted West Yorkshire Fire & Rescue Service. They told us they had issued a notification of deficiency in relation to shortfalls in the fire risk assessment, the evacuation procedures, record keeping and the need for some additional fire detection. They told us the provider had agreed to carry out the necessary work and they would be going back in November 2014 to follow this us. Following the inspection we spoke with the newly appointed manager at Spring Bank and asked them what progress had been made with the fire safety work. They told us they were not aware that West Yorkshire Fire & Rescue Service had carried out an inspection of the service.

Inadequate

Is the service safe?

A person who contacted us after the inspection said they had visited the service in the evening and found the outside lighting was poor. They were concerned this could be a risk to people's safety.

This demonstrated the provider did not have suitable arrangements in place to make sure people were protected from the risks of unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked around the home we found it was clean.

We found staffing levels were adequate to ensure people's needs were met. We looked at the staff duty rotas for November 2014 and previous months. The rotas showed that between the hours of 7:30am and 4.00pm there was usually one registered nurse and four care workers on duty. There were three care workers and a nurse on duty between 4pm and 10pm and overnight from 10pm until 7:30am there was one nurse and two care workers on duty. We saw that where necessary agency staff were used to cover absences to make sure there were enough staff on duty. The staff we spoke with told us there were enough staff to meet people's needs and keep them safe. During the inspection we observed staff were kept busy. They chatted to people as they carried out their various tasks but we did not observe staff having time to just sit and talk to people.

We looked at six staff files. The majority contained all the required documentation and showed the required checks had been completed before new staff started work. This included fully completed application forms, references and Disclosure and Barring checks. In one case we found there was only one character reference in the file. The person had not been previously employed in a social or health care setting. We discussed this with the manager who said they would deal with it.

There were no staff subject to disciplinary action at the time of the inspection. The manager was able to tell us the process they would follow in respect of investigations and disciplinary action.

Inadequate

Is the service effective?

Our findings

At the last inspection in June 2014 we found the provider did not have suitable arrangements in place to make sure people were cared for by staff who were properly trained and supported. We issued a warning notice telling the provider they had to take action to make sure staff received the training and support they needed to deliver safe and appropriate care.

At that time we found the provider had not paid their external training provider and as a result any training which had been delivered had not been assessed. This meant there was no way of checking the quality of any training which had been delivered. During this inspection we found this had been addressed and an external training provider had issued certificates for the training which had been delivered. In addition, the new manager told us they were in the process of changing the training provider and would start to roll out training to staff as soon as the new training packages were delivered.

The new manager had been in post for two weeks at the time of the inspection. They us they had delivered training on the Mental Capacity Act to 10 staff and dementia awareness training to 12 staff. This was confirmed by the records we looked at.

During the inspection we looked at the staff training records. Following the inspection the manager provided us with an updated copy of the training matrix and copies of training certificates

The training matrix showed there were 30 staff employed at the home. The training records were kept in six lever arch files, each of which contained training certificates for individual members of staff. The first file we looked at was labelled as containing the training records of five members of staff, it was empty. In addition, when we looked at the training matrix we identified the names of four staff for whom there were no training records in the lever arch files. This made it very difficult to establish what training had been delivered.

The information on the training matrix was also difficult to follow, in some cases it showed the date the training had taken place, in others it showed the expiry date of the training. The matrix did not have any information about planned training.

By comparing all three sets of records we were able to confirm that some training had taken place. For example, the records showed 22 staff were up to date with fire safety training, 17 staff had up to date moving and handling training and 18 had received safeguarding training. In addition, we saw some staff had received training on diet and nutrition, coping with aggression, infection control, first aid, diabetes and pressure ulcer prevention.

The manager provided us with a copy of a staff supervision planner. This showed staff who had attended group supervision the previous week. It did not indicate scheduled staff supervision for the future. We saw evidence of seven staff appraisals having taken place in 2014. The notes of a staff meeting which had taken place on 6 November 2014 stated the nursing staff would be responsible for carrying out the supervision of care staff. However, there was no evidence nursing staff had been trained to provide staff supervision. The notes of the same meeting stated the new manager would provide supervision for the nursing staff. However, the new manager was not a nurse and there was no information about how clinical supervision would be provided to nursing staff.

While it was evident that some training and supervision had taken place we could not be assured that the provider had made suitable arrangements to make sure staff were appropriately trained and supported to deliver safe and appropriate care and treatment.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in June 2014 we found the provider did not have suitable arrangements in place to make sure people were properly supported to maintain a balanced diet. During this inspection we followed this up to check if the required improvements had been made.

We found people were offered a choice of food and people told us they had plenty to eat and drink. One person told us, “The food is quite decent, plenty, I’ve never asked for more because I don’t need to.” Another person said, “I like the food, it’s very good, plenty of meat and vegetables. I don’t like fat and they cut it off if I ask them to.”

The service had a four weekly menu cycle. However, we found the nutritional value of the food provided could not be assessed because the meals were not prepared using standard recipes.

Inadequate

Is the service effective?

The menus showed the range of food people were offered for their evening meal varied to such an extent that the nutritional values were not comparable. This meant that some of the evening meals had a higher nutritional value than others. The menus indicated that there were some days when people may receive low levels of protein. There was no fresh fruit on the menu and we did not see any in the home which could result in people receiving low levels of vitamin C.

There was no clear approach to ensuring the needs of people who needed the texture of their food altering were met. For example, people who needed a soft or liquidised diet. This could mean that some people were receiving a liquidised meal when a softer meal choice would have been suitable. This could impact on people's enjoyment of their food which in turn could have an impact on the amount they ate.

No one living in the home at the time of the inspection needed a special diet to reflect their religious or cultural needs. The only people who needed special diets were those with diabetes and people who required the texture of their food altering. We spoke with the cook who was aware of people's dietary needs and preferences and was aware of how to add calories to food, for example by adding cream to porridge.

We looked at the weight records and found of the 16 people whose weight was recorded 11 people's weight was stable with only minor variations, three people's weight was fluctuating around 5 lbs either way and two people were losing weight. In the case of the two people who were losing weight there was evidence action had been taken. In the case of the person who had not been weighed there was information in their care plan about this. The weight records gave us an indication that people were receiving adequate nutrition to maintain their weight.

We looked at the care records of four people who needed support to meet their nutritional needs.

The nutritional assessment (Malnutrition Universal Screening Tool, MUST) used by the home was not available in all the care records we looked at. The provider told us the previous manager had archived some documents. We also found the MUST score had not always been calculated correctly or used for action, for example, to prompt a referral to other health care professionals. This had the potential to cause a delay in people receiving the right support to meet their nutritional needs.

In one person's care records we found this had happened. Their records showed they had lost a significant amount of weight in January 2014 but there was no MUST assessment in their file. The person had not been referred to a dietician until October 2014 and this had been prompted by concerns that the person was not eating. The delay may have been detrimental to the person's nutritional status and general health.

In another person's notes we found there was no record to show that all the nutrition products they had prescribed for them were being offered every day. The food and fluid monitoring record was not complete and therefore did not provide evidence that the care plan was being followed. The impact of this could be significant for the person as their nutritional needs could not be shown to have been met. This could result in weight loss and poor nutrition which in turn could increase the person's risk of developing infections or tissue frailty or skin damage.

We found there were nutrition care plans in place but they were not always kept up to date. In addition, they lacked clarity on the nutrition and hydration care pathway. For example, we found they did not have details about the texture of food and the thickening of fluids. This created a risk people would not receive the right support to meet their nutritional needs.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed the meal service at lunch time. Six people had their lunch in the dining room. The tables were set out nicely with cutlery, drinks and napkins. There was no menu to choose from and people were given what was cooked that day. However, people told us if they did not like what was on offer they could have something else. We saw this happening, for example, one person chose to have cheese and biscuits instead of a main course and another had an alternative pudding because they did not like fruit crumble. We observed one of the care workers supporting a person to eat; they were patient and attentive to the person's needs.

Inadequate

Is the service effective?

People in the dining room seemed to enjoy their food and cleared their plates. However, we found the dining room was lacking a pleasant social ambience where people could be encouraged to chat and to eat.

We spoke with five people who had their meals in their room. They said the food was tasty and plentiful. One person said, “The things I like most about living here is the comfort and the food”.

We observed people had jugs of juice in their room and people were offered plenty of drinks at lunch time. The drinks trolley went around mid-morning and mid-afternoon and people were offered a choice of hot drinks.

We found two people who lacked capacity to consent had been given medication in a disguised format. There was no documentation to show the best interest decision making processes had been followed in either case. In another person’s records we saw their relative had been asked to sign a consent form for the administration of a flu vaccination. There was no evidence to show the provider had checked the person’s relative had the legal authority to do this. In another person’s care records we saw information which said they must not go out alone. While it was evident from our discussions with staff they believed they were acting in the person’s best interests there was no evidence they recognised this meant the person was deprived of their liberty. There was no evidence a Deprivation of Liberty Safeguards (DoLS) application had been made. This meant the service was not working in accordance with the requirements of the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found people had access to a range of NHS services. Visits from external health and social care professionals such as GPs, nurse practitioners and speech and language therapists were recorded in people’s notes. The home had a “Telemedicine” link with the local hospital. This was provided via a video link and meant that when people sustained minor injuries they could be assessed by a medical practitioner to determine if they needed further treatment. This helped to reduce unnecessary visits to Accident and Emergency departments which could be distressing for people.

However, we found there was sometimes a delay in referring people to other health care professionals. This could result in a delay in people getting the right support to meet their health care needs.

Good

Is the service caring?

Our findings

The home had a warm and homely atmosphere. We spent time observing how people were supported and cared for in the communal lounges and dining room. We saw staff were kind, caring and compassionate in their interactions with people. There was a good rapport between the staff and people who lived in the home. We saw staff addressed people by their preferred names and interactions were relaxed and comfortable. We saw staff crouched down so they were at the same eye level as the people they were speaking with and they lowered their tone of voice.

We observed people looked clean and tidy and were wearing appropriate clothing and footwear. The bedrooms were clean and warm. We saw most people had personal possessions such as photographs and ornaments in their rooms.

We observed staff were attentive to people's needs. For example, we heard one of the care staff telling the nurse that one person had been coughing every time they had a drink. The nurse said they would check the person and if necessary would arrange for the person to see their doctor. We saw another person spilled some tea on their clothing and one of the care staff immediately helped them to go to their room and change.

The majority of people we talked with spoke positively about their experiences of using the service. One person said, "This is a nice place, I can recommend it, staff are very nice here." Another said, "I can't give them a bad word, never any problem." However, one person said, "Some staff are nice, others are not so good. If I want them I have to wait about 20 minutes and they shout "I'm here" when they come."

There were no restrictions on visiting. We spoke with two people's relatives and they told us they visited at different times and never had any concerns about the care.

One relative told us the home had been recommended to them by a friend. They said they thought Spring Bank was a good home and their relative had improved since moving in. Prior to moving into Spring Bank they said their relative had been at another home which was not as good.

Another relative told us they had no concerns about the care. They said, "Mum is happy and content. The staff are lovely, treat her kindly and always call her by her first name. I have no need to worry about her."

The staff we spoke with were able to tell us how they ensured people's privacy and dignity was respected. They also understood the importance of confidentiality and making sure people's personal information was kept safe.

Requires Improvement

Is the service responsive?

Our findings

Five of the seven people we spoke with told us they felt well cared for and said staff were gentle, considerate and competent. One person said, ''I'm not afraid if I will fall or slip when the carers are there." Two people's relatives told us they had no concerns about the care provided.

We looked at three people's care records. People's needs were assessed and the information obtained during the assessment process was used to develop care plans. The care plans included information about the support people needed with all aspects of their day to day lives. For example, mobility, eating and drinking, communication and skin care. The care plans were reviewed every month and were up to date.

When people were identified as being at risk, for example, of developing pressure sores there were plans in place to inform staff about the actions they should take to reduce the risk. However, in some cases the care plans were not detailed enough to give clear guidance to staff. For example, in one person's records there was no information about the type of incontinence products they used or the type of pressure relief equipment which had been provided. In another person's record we saw a body map had been completed with details of skin damage the person had sustained. However, there was no care plan in place to show what treatment the person was receiving. We spoke to the provider about this and they explained some of the difficulties they were having with providing appropriate treatment. We recommended they contact the tissue viability nurse specialist for advice.

In two of the three care plans we looked at there was no evidence that people who used the service, or those acting on their behalf, had been involved in developing or reviewing the care plans. This risked people not being enabled to participate in making decisions about their care and treatment.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care records included Personal Passports to be used in the case of an emergency admission to hospital. The Personal Passports contained essential information about people's needs and preferences and were used to share information with other professionals and reduce the risk of essential information about people's care and welfare needs being missed. This was good practice.

Most people had a file in their bedrooms which contained information about their past lives, interests, family, friends and likes and dislikes. This helped staff to get to know people as individuals and have a better understanding of their care and support needs. The staff we spoke with were knowledgeable about people's individual needs and preferences.

The Local Authority carried out a quality monitoring visit to the service in July 2014 and asked the provider to make sure information about planned activities was displayed so that people who lived in the home were aware of what activities were available. They asked the provider to do this by September 2014.

On the day of our inspection there was no programme of activities on display in the home. We observed a lot of people stayed in their rooms and watched TV. The people we spoke with could not really remember what entertainment, if any was provided. Two people said they went out in the afternoons for a walk with care staff and other people told us they went out with their relatives.

After lunch the new manager played the organ in the lounge for an hour. People seemed to enjoy this and some people sang along with the tunes. There was a game of Bingo later in the day. Staff told us a musician visited the home every week and said people enjoyed this. However, we found there was a lack of a structured approach to providing people with suitable activities.

The provider had a "Concerns and Complaints Procedure" which had been updated in November 2014. The procedure included timescales for investigating and responding to complaints. However, the information provided about how to progress a complaint if the person was not satisfied with the provider's response was not correct. The procedure stated unresolved complaints would be referred to the Care Quality Commission. The Commission does not have powers to investigate individual complaints. Providing people who already had concerns about the service with incorrect information could cause then additional, unnecessary distress. This demonstrated the provider was not providing people with appropriate support to have their concerns or complaints resolved.

Requires Improvement

Is the service responsive?

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the complaints file. The last formal complaint was in July 2014; this had been investigated and resolved in a timely manner and to the satisfaction of the complainant.

Five people who used the service told us they never had any problems and had not needed to complain. One person who expressed some concerns about the staff told us they had talked to their relative about their concerns. They said they did not know if anything had been done but added that since they had spoken to their relative they had not experienced any more problems. Two people's relatives told us they have never had any reason to complain. They said they would not hesitate to speak to the manager or staff if they had any concerns.

Inadequate

Is the service well-led?

Our findings

The registered manager left the service in November 2011. The provider told us they would appoint a new manager who would be required to register with the Commission. A manager was appointed in April 2014; however, they left in September 2014. The provider appointed another manager who took up their post on 3 November 2014.

The provider was present in the home most days. However, there was no registered manager for 12 months and this meant there was a lack of consistency in the management and leadership of the service.

The newly appointed manager had previous experience in managing a care service for older people and was registered with the Commission in their previous post. They told us they would be applying to the Commission to become the registered manager of Spring Bank Nursing Home. The new manager was not a nurse and we asked the provider what arrangements they had in place to make sure the clinical aspects of people's care were managed by a registered nurse. The provider told us one of the nursing staff was nominated as the "clinical lead" and they also told us they had a background in nursing and could provide support in this area.

When found the quality assurance systems that were in place were not effective. For example, when we looked at how people's medicines were managed we found they were not always managed safely or in line with the provider's medication policy. We asked about the systems in place for auditing medicines. The records which were available showed the medication systems had not been audited since May 2014. The provider was not aware of the shortfalls in the safe management of medicines until we brought them to their attention.

We looked at the systems for managing accidents and incidents. We found that accidents and incidents were recorded but there was no analysis to identify trends or patterns. This meant the provider was missing an opportunity to identity potential risks to people's safety and welfare and to take action to manage the risk.

We found when the provider was made aware of risks they did not always act quickly to manage or reduce the risks. For example, the provider had not taken action to address concerns raised by the environmental health inspection in timely way. In addition, the provider had not informed the new manager about the work which needed to be carried out to meet the requirements of fire safety regulations following a recent inspection by West Yorkshire Fire & Rescue Service.

This demonstrated the provider did not have an effective system in place to identify and manage potential risks.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following the last inspection in June 2014 the Commission met with the provider to discuss the shortfalls in the service. In order to reduce the risks to people's safety and welfare while improvements were being implemented the provider agreed not to accept any new admissions to the home.During this inspection we found that six people had started using the service between July and October 2014. When we looked at the records we found one of these people had passed away at the home. The provider had not informed us, the Commission, about this. In addition, we found the provider did not always notify us about incidents or events which they were required by law to tell us about. For example, when the Local Authority visited the service in July they found a person who used the service had been missing for several hours and the provider had not informed any of the relevant agencies. This demonstrated the service was not operating in an open and transparent manner.

The Local Authority (LA) carried out a quality monitoring inspection of the service in July 2014. Following the visit they sent the provider an action plan which identified a number of areas where action was needed to improve the service. The timescales for completion of the actions ranged from September to November 2014. The provider told us this work was in progress. On the day of the inspection we found the home did not have a programme of planned activities on display for the benefit of people living in the home. This was one of the actions on the LA action plan and should have been completed by September 2014.

We found systems relating to the management of the service lacked structure and organisation. For example, the records relating to staff training, supervision and appraisal were not clear and were incomplete. There was no clear plan in place to ensure all staff received the training and support they needed to meet people's needs.

Inadequate

Is the service well-led?

We found other shortfalls in relation to record keeping. For example, we found nutritional risk assessments were missing from some people's care records. In addition, when we looked at the staff recruitment files we found the records of checks carried out with the Criminal Records Bureau and Disclosure and Barring Service were not kept secure.

Following the last inspection in June 2014 we told the provider they must take action to address a number of shortfalls in the service. Although they had addressed some of the specific concerns, for example, they had provided us with a copy of the electrical wiring certificate; they had not taken sufficient action to ensure the service was safe, effective and well led.

The manager was visible throughout the day. The staff we spoke with said their initial impressions were that the new manager was approachable and willing to help them.

There was no evidence that people who used the service or their representatives had been given an opportunity to share their views of the service between June, when we last inspected the service and November when the new manager was appointed.The new manager told us they had sent out surveys to people's relatives and was just starting to receive feedback at the time of the inspection. They also told us they had asked a volunteer who visited the home to provide entertainment to conduct a survey with people who lived in the home. The manager told us they planned to discuss the results of these surveys to plan and implement changes to the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Safeguarding service users from abuse** **The registered person did not have suitable arrangements in place to identify the possibility of abuse and prevent it before it occurred and to respond appropriately to allegations of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Management of medicines** **The registered person did not have suitable arrangements in place to protect people from the risks associated with medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Safety and suitability of premises** **The registered person did not have suitable arrangements in place to make sure people were protected from the risks of unsafe or unsuitable premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	Supporting workers The registered person did not have suitable arrangements in place to make sure that staff employed for the purpose of carrying on the regulated activities were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to people who used the service safely and to an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Consent to care and treatment The registered person did not have suitable arrangements in place for acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Complaints The registered person did not have suitable arrangements in place to provide people who used the service, or those acting on their behalf, with appropriate support to have their complaints fully investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Respecting and involving service users

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place to ensure people who used the service were enabled to participate in making decisions about their care or treatment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not have suitable arrangements in place to ensure people who used the service were protected against the risks of inadequate nutrition and dehydration.**

The enforcement action we took:
We issued a warning notice and told the provider they must take action to comply with the regulation by 23 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to regularly assess and monitor the quality of the services provided and to identify, assess and manage risks to the health, welfare and safety of people who used the service and others.**

The enforcement action we took:
We issued a warning notice and told the provider they must take action to comply with the regulation by 23 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not have suitable arrangements in place to ensure people who used the service were protected against the risks of receiving unsafe or inappropriate care by maintaining accurate records.**

The enforcement action we took:
We issued a warning notice and told the provider they must take action to comply with the regulation by 23 March 2015.