Orchid Care Homes Limited

Springfield Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Springfield Residential Care Home is registered to provide accommodation and care, without nursing, for up to 29 older people. The home is a Victorian property in a residential area of March, within walking distance of the town centre. The original house has been extended and provides accommodation on two floors.

This was a comprehensive inspection. The visit to the home took place on 16 January 2017 and was unannounced. There were 25 people living at the home when we visited.

At our previous inspection, in January 2016, we found that the provider was in breach of two regulations. We found that people were at risk of inappropriate care as their care plans did not reflect their needs and that people were not protected against risks to their health and safety. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

During this inspection in January 2017 we found that improvements had been made and the provider was no longer in breach of the regulations.

Although we saw some kindness and compassion, we also saw that staff did not interact with people or engage them in conversation. Staff did not always treat people with respect, ensure people's privacy and dignity were maintained or support people to be independent. People's personal information was not always kept securely. Visitors were welcomed.

There was not always a sufficient number of staff on duty to make sure that people's needs were met in a timely manner. Staff had received an induction and had undertaken training in topics relevant to their role. Staff had been recruited in a way that made sure that only staff suitable to work in this care home were employed.

Audits of a number of aspects of the service provided had been carried out, action plans put in place and some improvements undertaken. The audits had not always identified the issues we found. Records were maintained as required.

This home requires a registered manager as a condition of its registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. At the time of this inspection there was a registered manager who had been at the home for almost 25 years.

People and their relatives were mostly content with the service provided at Springfield Residential Care Home. Staff enjoyed working at the home and were supported by the registered manager and deputy manager.

Staff had undergone training and knew how to recognise and report any incidents of harm or abuse. Most potential risks to people had been assessed and guidance provided for staff so that the risks were minimised. Medicines were managed well, which meant that people received their prescribed medicines safely.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had not always been fully assessed and some staff had a limited understanding of the principles of the MCA and DoLS. This was being addressed by the managers. Appropriate applications had been made to the relevant authorities to ensure that people's rights were protected if they lacked mental capacity to make decisions for themselves.

People's healthcare needs were monitored and staff involved a range of healthcare professionals to make sure that people were supported to maintain good health and well-being. People were given sufficient amounts of food and drink and people's dietary needs were met.

Pre-admission assessments had been carried out. People and their relatives had been involved in planning the person's care and support. People's care plans gave staff information about the ways in which each person wanted their care and support delivered. The care delivered was not always personalised and not always delivered in a timely manner.

Complaints were listened to and addressed. The activities and entertainment that were planned and delivered were limited and were not based on people's individual interests or hobbies.

The managers were approachable and supportive. People, relatives and staff were given opportunities to share their views about the service and put forward ideas for improvements. Notifications relating to significant events in the home were sent to CQC as required.

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.

Most potential risks to each person had been assessed.

Staff had undertaken training in safeguarding and were aware of the procedures if they suspected anyone was at risk of being harmed. Staff recruitment meant that only staff suitable to work at this home had been employed.

Medicines were managed well, so that people received their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

Staff received an induction and were supported by management. Further training had been arranged to make sure staff were knowledgeable and skilled to carry out their role.

Arrangements were in place to ensure that people's rights were protected if they did not have the mental capacity to make decisions for themselves.

People were provided with sufficient food and drink to meet their nutritional needs. Healthcare professionals were involved to make sure that people's health was monitored and maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always kind and compassionate. They did not always treat people with respect and did not always support people to maintain their privacy, dignity and independence.

People were given opportunities to make choices about some aspects of their lives.

Visitors to the home were welcomed. An advocacy service was advertised if a person needed an independent person to act on

their behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always personalised and was not always delivered in a timely manner.

The range of activities, entertainment and outings was limited and was not based on people's individual hobbies and interests.

Complaints were encouraged and addressed.

Is the service well-led?

Good

The service was well-led.

A quality assurance system was in place.

The managers were approachable. People, their relatives and the staff had a number of opportunities to put forward their views about the service provided.

CQC was notified of events as required.

Springfield Residential Care Home

Detailed findings

Background to this inspection

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

This inspection included an unannounced visit to the home on 16 January 2017. The visit was carried out by one inspector 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.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

In December 2016 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assist with planning the inspection.

During our visit on 16 January 2017 we observed how the staff interacted with people who lived at Springfield Residential Care Home. We spoke with ten people who lived there and five of their relatives. We also spoke with seven members of staff: four care workers, the cook, the registered manager and the deputy manager. We looked at two people's care records as well as other records relating to the management of the home. These included records relating to the management of medicines, accident and incident records, staff rotas and an audit that had been undertaken by an external consultant in November 2016.

Good

Is the service safe?

Our findings

At the previous inspection in January 2016 we found that people were not always protected against risks to their health and safety. Assessments of risks to individuals had not always been updated following an accident or incident. Also, we found that there were hazards such as obstruction to fire exits and harmful chemicals not stored safely. The provider sent us an action plan describing the actions they would take to meet the regulation. They said the actions would be completed by 11 April 2016. During this inspection we found that there had been improvements in these areas and the provider had completed their planned actions and maintained the improvements.

However, we found that there were still some areas in which further improvement was required. Assessments of a number of potential risks to people had been carried out. These assessments included mobility, falls, nutrition and the risk of a person developing pressure sores. There was guidance in place for staff so that any risks were minimised. However, no assessments of risk had been carried out for the use of bed rails.

We checked whether there were enough staff to keep people safe. On the day we visited one member of staff had called in sick so the staff member employed to do the cleaning had stepped into the role of care assistant. The registered manager said they did not use a formal systematic approach to work out how many staff were required, based on people's needs. They said the number of staff on duty on each shift had not changed for many years, but they told us they did review staff numbers on a regular basis to ensure there were sufficient staff to keep people safe. Staff were busy and very task-orientated, but we did not see any evidence that people were not physically safe.

The managers told us, and staff confirmed, that the provider had a robust recruitment procedure in place. New staff were not able to start work until all pre-employment checks, such as a criminal record check, references from previous employers and proof of identity, had been obtained. This meant that only staff suitable to work in this care setting had been employed.

Three people told us they felt safe living at Springfield Residential Home. One person told us, "Oh, I do feel safe. It is all locked up and the windows closed." Another person told us, "I do feel safe here." However, two other people shared their concerns with us about having a bedroom on the first floor. One person told us, "I am terrified of the stairs and the stair lift terrifies me. The home could do with a lift." A relative agreed with this.

Staff showed us that they understood that safeguarding meant keeping people safe from harm and abuse. They demonstrated they would recognise different forms of abuse and they knew to whom they would report any concerns. They told us that there was a folder in the office with details of external agencies to contact and they confirmed they had undertaken safeguarding training. People told us they felt safe with the staff. One person said, "I've been here for [a number of] years. The staff wouldn't … hurt me."

Personal emergency evacuation plans (PEEPs) were in place. This meant that everyone, including external

agencies such as the fire service, would know the assistance each person needed if, for example, there was a fire or flood. We noted that risks to people's safety raised at our last inspection had been removed. We were concerned about the safety of some of the windows, especially in the upstairs bedrooms and on the stairs. Following the inspection we wrote to the provider who confirmed that they were taking steps to ensure that all windows were safe.

We looked at the way people's medicines were managed and found they were managed well. People told us that the staff gave them their medicines and that they were always on time. One person also told us that staff always washed their hands before instilling their eye drops. Medicines were stored securely and at the correct temperatures. Records were kept as required. Medication Administration Record (MAR) charts showed that staff had signed each time to show that a person had taken their medicines. If they had not taken the medicine, proper procedures had been followed. There were protocols in place to guide staff on how and when to give medicines prescribed to be given 'when required'. We checked whether the number of tablets remaining in the boxes tallied with the amounts recorded on the MAR charts: there were no discrepancies. This meant that people were receiving their medicines safely and as they had been prescribed.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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.

During their November 2016 audit, the external consultants found that there was a lack of suitable documentation in people's care records relating to any assessments of capacity. The registered manager told us that everyone who lived at the home had the mental capacity to make at least some of their own decisions relating to their care and treatment. Three people could make day to day decisions but would not have been safe if they left the home unsupervised. Appropriate applications had been made to the local authority for DoLS authorisations so that these people would be kept safe.

We spoke with three members of staff who told us they had undertaken training relating to the MCA. Two of these staff said they had also undertaken training relating to DoLS. However, we found that their understanding of the MCA and DoLS was limited and they were not confident that they had sufficient knowledge regarding the MCA and people's capacity. The registered manager told us they were aware that most of the staff would benefit from more training, which had been arranged. One of these staff was more confident in their understanding of DoLS, knew who had a DoLS application in progress and was able to give us a good example of why someone was being deprived of their liberty.

Following the inspection visit, the managers told us they had spoken to the MCA and DoLS trainers and were putting revised documentation in place. They had arranged further training for staff. Some of this was arranged with an external trainer coming to the home. The registered manager said this was very effective because "we all know each other and don't feel silly asking questions." The deputy manager had updated care plans with further, more in-depth guidance for staff so that "the least invasive options" relating to care would be pursued before best interests decisions were made. When a decision had had to be made in the person's best interests, this had been discussed with relevant healthcare professionals and the person's relatives and then fully recorded.
We looked at whether staff had the knowledge and skills to do their job properly. Staff told us they had undergone an induction period when they started working at Springfield Residential Care Home. The induction included training and working alongside experienced members of staff.

Staff said that they had undertaken training in a range of topics related to their work. These included moving

and handling; food hygiene; dementia; end of life care; first aid; medicines; and equality and diversity. They said that the registered manager organised all the training and reminded staff which courses they needed to attend. Refresher training was regularly available to make sure that staff were up to date with their training. We saw notices on the board from the registered manager advising them of up-coming training sessions and which staff were to attend. One member of staff said, "There's loads of training, everything" and went on to tell us a list of the training they had attended. Another member of staff told us that as well as attending training in how to handle medicines, the deputy manager checked, at least twice a year, that staff were competent to give people their medicines.

Staff told us they felt very well supported by the managers. They had regular supervision sessions and an annual appraisal. They also told us they felt well supported by each other and that they worked well as a team.

This meant that the provider had ensured that staff had the knowledge, skills and support to do their job properly.

People were supported to have enough to eat and drink. The provider used a system of prepared foods, which were specifically made to support the nutritional requirements of older people. People told us they enjoyed their meals. Their comments included: "It'll be nice, yes it's usually cooked very well"; "The meals are alright. They couldn't be better"; "The meals are good, there is enough for me"; and "The food is fine. Lovely dinner." A relative told us, "The food looks nice." Another relative said, "The food is okay. There's something different every day, but each week is the same."

Staff used a recognised tool to assess people's risk of malnutrition and dehydration. Each person was weighed each month and advice from the GP sought if there had been significant weight loss. Each person's nutritional requirements were recorded in their care records and modified diets were provided for people who needed them. For example, we saw that a different dessert was given to people with diabetes. A relative told us, "[Name] is on food watch and fluid intake. Staff tell the family if [name] isn't eating." We saw that this person's food and fluid intake was recorded on a chart in their bedroom. Staff confirmed that each person's needs relating to their food and drink were recorded in their care plans and were also listed in the kitchen. They said the cook would always tell them who required a "special meal".

People were supported to maintain good health by a number of healthcare professionals who visited the home. These included the GP and district nurses. Records showed that medical issues had been followed up. For example, one person had complained of knee pain so staff, on GP's advice, had taken the person for an x-ray. Another person had been referred to the mental health team. Care records included a record of all 'professional visits'. Care records also contained documents to go with the person if they were admitted to hospital. These 'grab sheets' included information about the person, their medical history and medication they had been prescribed. The deputy manager told us the information was kept up to date so that it was ready when needed.

Requires Improvement

Is the service caring?

Our findings

People and their relatives had mixed views about the staff. Some made very positive comments, such as "The staff are respectful and speak nicely to me"; "The staff are all good, they speak nicely to me"; "I can't fault the staff"; and "I find the staff kind and considerate." However, other people's comments were not so positive. One person said, "There is a lack of understanding about the needs of the elderly. The faces of some of the carers are not friendly."

The external consultant who audited the service in November 2016 reported that they observed 'all residents treated with respect and dignity…staff knocked on doors before entering…it was nice to hear general conversation at all times to residents…staff assisted residents with personal hygiene matters in a quiet and dignified manner.' However, on the day we visited we had a very different experience.

We saw little interaction between staff and people who lived at the home. We did not observe staff taking time to have conversations with people. Any communication was limited and functional. We observed staff sitting in the lounge but not engaging with people. We noted that one member of staff walked through the dining room while people were having their lunch. The staff member did not acknowledge anyone in any way as they passed through the room.

When we asked one of the staff about speaking with one of the people who lived at the home, they said we would not be able to: "Oh no. They are deaf." We did not see and were not told about any alternative methods that were used to enable this person, or anyone else, to communicate. We have since received copies of two care plans which show that communication with each person is explained. Nevertheless, staff did not explain this to us at the time.

People told us that they had choices in some areas of their lives. However, we also noted or were told about a number of occasions when people were not given a choice. Several people had chosen to stay in their rooms most, if not all of the time. Menus showed that there was a choice of meals. One person told us, "Meals are reasonable, you get two choices at meal times." At lunchtime we saw that there was a choice of two main meals. People were asked to choose at the time of the meal. The meal arrived at the table plated up, so people could only choose between the sausages or the chicken casserole: they did not get a choice of vegetables nor of the quantity of food they would have preferred. A relative said, "It's all dished up when it comes in." Gravy was sent from the kitchen in a large jug, so people could choose how much, if any, they wanted. One person in their room was not given a choice of which of the main meals they wanted. A plate of food was just put next to them. After lunch, a member of staff entered the dining room and gave two people a cup of coffee. It had not been discussed with anyone in the dining room whether they wanted a drink and if so, what they would like. During the afternoon people sitting in the lounge were given a cold drink. Although there was a choice of two flavours of squash or water, the member of staff did not ask anyone which they would like. They handed each person a glass, just saying the person's name and the flavour of the drink they were being given.

Staff did not always respect the decisions that people made about their care. A member of staff told us that

one person "rings the bell to get changed for bed, but we say it's early and tell them 'in 10 minutes'. This goes on until we get them ready for bed, which seems to settle them." Care plans indicated that people were supported to be independent. For example, one care plan stated '[Name] will wash and dry [their] own hands and face if passed the flannel and towel.' However, people were not always enabled to be independent. For example, one person was concerned that they had to rely on staff rather than being able to use the stair lift independently. At lunchtime, one person's walking aid was moved away from them, out of their reach, when they sat down. This meant they had to wait for staff assistance before they could leave the dining room. This also put this person at risk of falling: we saw them try to reach the walking frame because no staff were available to get it for them.

One person told us that staff treated them with respect. They said, "They [staff] call me by my name." However, another person told us, "The staff call me darling. I do not like that." One person told us that staff "can be sarcastic at times", which this person said they did not like. One staff member used language that did not show respect: they described some people as "the ones who are with it", meaning those people who were not living with memory loss or dementia.

Staff did not always treat people with dignity. During the inspection visit, in the lounge, one staff member saw a person stand up and said, loud enough for others to hear, "Oh look, [name] has wet themselves." The staff member did not immediately offer to assist them.

Dignity was also not respected by issues to do with the environment. A few of the carpets were stained and dirty, some of the curtains were not properly attached to the rails and the general décor was shabby. One family member told us, "The décor is dated." We noted that there was little appropriate signage to aid people living with dementia. For example, bedroom doors only had a number on them, with no guidance for someone whose memory might have needed other prompts for them to recognise and independently access their own room or the toilet. On arrival we noted that there was a very strong, unpleasant odour in a number of areas of the home. This was not helped when staff used air freshener and the odour did not improve throughout the day. A relative told us that a member of their family had said, "You can smell urine as soon as you walk in." Another relative said, "There is sometimes a urine smell but it can't be helped." Following the inspection the provider told us that they had "conducted a survey of visitors to the home to determine whether they can smell urine. None of the visitors said they that they could detect any offensive smells when they came in." The provider also told us that they had decided (in one person's room) "to try a change of flooring to see if this makes a difference."

Staff told us ways in which they maintained people's privacy, such as knocking on doors and closing curtains when delivering personal care. However, during the inspection visit, staff did not always respect people's privacy. We were talking to one person and their relative in the person's bedroom when a member of staff walked in without knocking.

People told us that they were encouraged to maintain contact with family and friends and that their visitors were made welcome. One person told us they had their own landline and telephone, which was their "lifeline". They said that they were able to use another lounge when family visited and brought a picnic. One relative told us they were welcome at any time but another relative told us they could come at any time except mealtimes. The deputy manager told us that relatives visiting at a mealtime were offered "something to eat, especially if they've travelled some distance."

The home had received a number of written compliments. A person described their respite stay as 'most pleasurable' and 'much appreciated'. One family wrote, 'Thanks [for] taking care of dear [Name] who spent many happy years at your care home. It was like home from home for him… We as his family have fond

memories visiting him and know that he was happy and thought so much of all the staff.' Another family wrote, 'Thank you for taking care of our [family member] … with love and compassion and respect.' A third family's card included, '…thank you for the kindness and excellent care you gave [family member]. [They were] very happy and always singing your praises.' We saw some examples of staff treating people with kindness and compassion.

People's confidentiality was not always respected. Some copies of care records were kept in a folder by the front door, with the PEEPs, so that the information was available in the event of an emergency. Although this had been done with the best of intentions, staff had not recognised that the records included confidential personal information which was then available for anyone to look at. This was moved to a more secure place when we pointed this out.

We noted that advocacy services were advertised so that people or their relatives could contact an advocate if the person needed an independent person to act on their behalf.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in January 2016 we found that people were at risk of receiving inappropriate care as their care plans did not reflect their needs and information in care plans was not up to date. The provider sent us an action plan describing the actions they would take to meet the regulation. They said the actions would be completed by 11 April 2016. During this inspection we found that there had been improvements in this area and the provider had completed and maintained their actions.

The registered manager told us that each person underwent a pre-admission assessment to ensure that their identified needs could be met by the staff team. People's relatives were encouraged to visit the home before the person was admitted but the registered manager said it was very rare for the person themselves to visit. Following admission, a temporary care plan was put in place, based on the assessment. Staff told us they learnt about people's needs from the care plan and also from verbal information at handovers. The registered manager said a full care plan was put in place within a month, which included staff's input from working with the person.

In the PIR the provider wrote, 'Person-centred care plans are compiled when service users join the home. Service users are asked to be involved with the care plans and to agree their content.' We found that care plans were personalised and gave detailed guidance to staff on the care each person needed. The details included the ways in which each person could be supported to be as independent as possible. A 'This is me' leaflet (developed by The Alzheimer's Society) gave staff information about the person such as their past life, family, interests and work history. This helped staff get to know the person.

However, we found that the care delivered was not always personalised. For example, staff told us that each person was offered one bath a week, regardless of their preference. People did not always get the assistance they needed. One person told us they had great difficulty eating due to arthritis in their hands. Staff did not offer to assist them and we saw no evidence that other assistance, such as modified cutlery, had been offered.

People did not always get the care they needed in a timely manner. One person told us, "Recently it was very short-staffed, staff sickness I think….the staff are always busy." Another person told us, "The carers say 'In a minute dear', which results in no care at all." A third person commented that "the call bell isn't answered as quickly at night."

Staff told us, "Sometimes [there are] enough [staff], sometimes not." Another member of staff said, "Sometimes there are not enough staff." Staff told us they did not have time to provide activities or to sit and spend time with people. They told us that people did not always get their weekly bath as there was not enough time. We noted this during our visit, and we saw that staff were very task-orientated. Care staff told us that in the afternoons they had to prepare and cook the evening meal as well as repositioning people and administering medicines. There were days when they had to do the laundry. On the day we visited, one member of staff had called in sick so the cleaner had stepped in to assist with the care. They had received sufficient training to be able to do this but they told us they preferred to do the cleaning "because I can chat

to residents in their rooms." When cleaning staff had to act as care assistants, it meant that the time allocated for cleaning was severely reduced.

The provider employed staff to plan activities and the registered manager and other staff said the activities staff were good at organising things for people to do. However, no activities staff were on duty on the day we visited and there was nothing for people to do other than watch the television. People had no expectation that any activity would be taking place. One person showed us they had done silk flower arranging "the other day" and said there was bingo, singing and "the chapel come one day a week." Another person told us there were "not a lot of activities." A third person said, "Staff keep saying I should play bingo. I didn't play bingo before coming here so why do I want to play it now?" A relative told us there was "little entertainment. About once a year for Christmas." They added, "[Name] isn't taken out, not even wheeled up town by staff." This meant there was a lack of meaningful activities and those that were organised were not based on people's individual interests and hobbies.

Staff told us they knew how to support people to make a complaint if they wanted to, but they said that people did not make complaints. One staff member said, "I think the residents are happy here. The residents would talk to us [staff]." The provider had a complaints procedure which was displayed on the notice board and was included in the information given to people when they first arrived. In the newsletter that was sent to people and their families, the registered manager had asked people to contact the office at any time if they wished to discuss any issues. The registered manager told us that any complaints had always been responded to and addressed. They said they always discussed complaints and incidents with the staff so that the whole team could learn from what had happened.

Good

Is the service well-led?

Our findings

The provider had a system in place to monitor the quality of the service being delivered to people by the staff. In November 2016 the provider had employed an external consultant to carry out a full audit of the service being offered at the home. They had noted a number of areas for improvement. The registered manager had developed an action plan based on the consultant's findings and there was evidence that some actions had been completed. For example, the torn carpet in the first floor corridor was being replaced the week after our inspection visit; meals were covered when presented to people; gravy and custard were served from jugs so that people could choose how much they wanted; and a maintenance plan was in place. Some identified shortfalls had not been addressed. For example, covers had not been fitted to radiators some of which were extremely hot on the day we visited, and wooden window frames had not been repaired. Following our inspection the provider explained that the report had been received only a few weeks before our inspection visit and told us that they were still in the course of addressing the issues where necessary. This included gathering quotes to repair the window frames.

The quality monitoring system also included audits of a number of aspects of the service, which were undertaken by the managers and each week the registered manager sent a report to the provider. However, the report to the provider was extremely brief and the provider rarely visited the home to carry out their own checks. Following the inspection the provider stated that there was "constant, extensive communication between the provider and manager by phone/email" and that provider visits were "carried out from time to time when appropriate." Nevertheless, the provider's quality assurance system had not identified a number of the issues we found during the inspection.

There was a registered manager in post who was in their 25th year of working at Springfield Residential Care Home and the deputy manager had worked there for 16 years. Most of the staff had also worked at the home for several years. Staff told us how much they liked working at home. One member of staff said, "I love it here, absolutely love it." They added that they "get on really really well with all the staff. We work as a team, which is nice." People told us they knew who the managers were. One person said, "The managers are nice, approachable and have time to chat.

Some people told us they were content to be living at Springfield Residential Care Home. One person said, "I had to go somewhere due to illness. The family looked around first, then I had a look at a few, this was the best [in the area]." A relative told us, "We would change nothing. We had looked around, several places, and this one seemed to be the best we could find." In their response to the quality assurance questionnaire, the registered manager reported that one relative wrote, 'Could not wish for [family member] to be better cared for. Thank you one and all.' During our visit we met one person who had chosen to move to another care home because they were not happy with the service they were being provided with.

The provider had a whistleblowing policy in place and staff told us they understood that whistleblowing meant reporting a colleague for poor practice. One member of staff said they had once reported another member of staff to the manager and the matter had been sorted out.

Some links with the community were maintained. For example, people told us that 'the chapel' visited every week to hold a religious service in the lounge. However, other people and staff felt that people had little opportunity to be part of the local community. The newsletter showed that there were plans to have 'a few "up town trips" when the weather improves'. The newsletter also stated that the manager 'will be arranging more entertainment within the home in December 16, February, April and August 2017.'

Meetings were arranged three times a year for people living at the home and their relatives, to give them the opportunity to comment on the service being provided and to make suggestions for improvements. Staff meetings were held every other month and minutes shared with staff who were not able to attend. A written questionnaire was sent to people, their relatives, staff and others who were regularly at the home such as the hairdresser and chiropodist. The results were evaluated and were shared with everyone in the newsletter that was produced three times a year. The registered manager reported that in October 2016, 24 questionnaires were sent to people living at the home and 16 were returned. Comments from the questionnaires, both positive comments and suggestions for improvements, were listed in the newsletter and a response from the manager had been included.

Required records were maintained. The registered manager was aware of their responsibility to send notifications to the CQC as required by the regulations.