Springfield House (Oaken) (2001) Limited

Springfield House Residential

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 8 and 9 December 2014 and was unannounced. Springfield House provides personal care to up to 36 older people. On the day of this inspection there were 23 people accommodated at the home.

There had not been a registered manager in post since January 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At the last inspection in June 2014 we asked the provider to take action to make improvements to people's care and welfare, record keeping and the monitoring of the quality of care. Action had been taken but improvements were still needed.

People told us they felt safe. Staff knew the signs that may indicate people were abused and were clear of the

Summary of findings

action to take. They were aware of their responsibility to protect people from harm or abuse. They told us they were confident that any concerns they reported would be acted upon.

Risks to people were identified. Plans were in place and acted upon to minimise risk to people.

There were sufficient staff to provide people's care in a safe way. The staffing levels were regularly monitored and adjusted to take account of people's needs. The provider had a robust recruitment process that ensured people were supported by staff whose suitability had been checked. Staff were supported and trained to provide people with care to an appropriate standard.

People had an individual plan of care that detailed the support they needed and how they wanted this to be provided. However, we found that some people's support was task based and was not provided in the way people wanted. We also saw that some people including those living with dementia did not have sufficient things to do. People were left for periods with no interaction or stimulation. Activities were not consistently taking account of people's wishes.

Appropriate systems were in place to store, record and administer medicines. This supported people to have their medicines at the right time and in the right way.

Care staff were not consistently following the provisions of the Mental Capacity Act 2005. Mental capacity assessments were not always completed. When people did not have capacity there was no information to show that decisions were made in their best interest. This meant that people's rights may not always be upheld.

People were supported to have sufficient to eat and drink. People could choose from a selection of meals and drinks. Where people needed support to eat and drink this was provided. The health care needs of people were addressed. People were supported to access health care services. When people were ill the doctor was called and when they needed specialist support this was provided.

People told us they found the staff caring and compassionate. People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

We observed and people told us that there were occasions when people's dignity was not fully promoted. Some people were not able to wear their own clothes due to problems with the laundry facilities.

The provider had a range of checks and audits in place but these were not always effective. The checks had identified some shortfalls we saw and when actions were taken to address concerns these were not always effective.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

Arrangements were in place to make sure there were enough staff to keep people safe. The level of staffing took account of people's individual needs. People were supported by staff that had been subject to a robust recruitment process.

Risk to people were identified and assessed. Plans were in place to minimise the risk to people. When accidents and incidents occurred action was taken to lessen the likelihood of a reoccurrence.

Care staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not fully understood and follow the legal requirements of The Mental Capacity Act 2005. This meant that people's rights may not be upheld.

People had sufficient to eat and drink. People's nutritional needs were assessed and monitored. People were supported to have their health care needs met.

Care staff had the training and support to provide people's care effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt that staff were caring and they were treated kindly.

People were included in decisions about their care and relatives felt involved and free to visit when they wished.

There were times when people's dignity was not fully promoted. Some people could not wear their own clothes or did not have the appropriate clothes to wear.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were in place that gave information about people's care needs. These were reviewed every month. This meant that staff had up to date information about people's needs.

People were not always supported to receive care that met their needs. Some people's care was not provided in a timely manner.

Summary of findings

Some people were not supported to take part in activities that took account of their needs and wishes.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had not been a registered manager at the home since January 2014. Although temporary managers had been in post a registered manager who had the responsibility for people's care was needed to provide consistency and continued improvements.

Care staff felt supported and were confident that the managers would act if they had concerns about other staff's practices.

The provider's checks and audits had not identified some areas that needed to be addressed to improve care people received.

Springfield House Residential

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 was 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 8 and 9 December 2014 and was unannounced.

The inspection team comprised of 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. The expert by experience had experience of supporting older people including people living with dementia.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection.

During our inspection we spoke with 11 people who lived in the home, six relatives, two senior care staff, two care staff, the unit manager, the acting manager and a clinical facilitator who was working at the home to support the development of the home. We also spoke with a health care professional and social care professional to gain their views about the care provided. We observed care and support in communal areas and looked at the care records of two people. We also looked at records that related to how the home was managed.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe living at Springfield House. One person said; "It's quite safe here". A relative said; "[Relative's name] is very safe there". Care staff we spoke with were aware of how to recognise different types of abuse and the actions to take if they had any concerns over people's welfare. We saw a flow chart on the wall giving care staff information about the action to take if concerns were identified. Records confirmed that most staff were trained in safeguarding people and we saw evidence that confirmed further training was arranged to take place two days after this inspection. We spoke with both the unit manager and the acting peripatetic manager. They were aware of their responsibilities and were able to describe the actions they would take if they suspected a person had been abused. Notifications sent to us confirmed that incidents of potential abuse were referred for investigation correctly. Information from the local authority showed that the provider co-operated and worked with external staff when concerns were identified.

Arrangements were in place to manage risks to people whilst respecting their rights. One person we spoke with said they used bedrails. They told they wanted to use the rails as it helped to make them feel safe. We saw that a full risk assessment was completed to check that the use of rails was safe and appropriate for this person. We observed people being moved safely. People who used the service told us two staff always supported them to use the hoist. One person told us; "I feel safe when I am moved". This was confirmed by our observations. Care staff we spoke with knew how to use a hoist and knew the type of sling each person needed to be moved safely. We saw that the risks of people acquiring pressure ulcers were assessed and where needed action was taken to minimise the risks. For example one person needed pressure relieving equipment and we saw this was provided.

The provider was evaluating safeguarding events, accidents and incidents and took action to prevent incidents reoccurring. For example when there had been an error in the administration of a medicine, a daily auditing system was introduced and staff had been retrained. Also when one person fell out of bed the level of night checks was increased and a soft mattress was placed by the side of the bed. This meant that the staff would quickly pick up any future incidents and if the person fell again the likelihood of them being injured was reduced.

The provider completed safety checks on the environment and equipment. For example electrical goods were checked and equipment such as hoists and the vertical lifts were serviced. A fire risk assessment completed in September 2013 identified that work was needed to ensure the premises complied with fire safety standards. An action plan was in place to rectify these shortfalls. We were sent information showing that funding for the corrective works had been submitted to the provider for approval. The provider was in the process of updating the personal evacuation plans to make sure that people would be kept safe in the event of an emergency.

People gave us mixed views about whether they felt there were sufficient staff on duty to meet their needs. They told us that there had been a high number of agency staff and they felt they had not received consistent care. We saw this had improved and recent rosters showed that few agency staff were being used. There had been a number of staff recently recruited which included two senior staff members. There had been an increase in the care staffing levels since our last inspection.

We spent time observing care in the dining room at lunchtime and saw there were sufficient staff to support people to eat. Some people told us they waited for care and although we saw people waiting for care this was for quite a short period. The provider had a staffing dependency tool in place that identified the level of staff required to meet people's needs. This took account of people's individual needs and also the design and layout of the building. We saw the staffing dependency tool was regularly completed. An examination of a sample of rosters showed us that staffing levels were consistently above those identified as needed by the dependency tool. The acting manager told us they could provide additional staff over what was recommended if they felt it was needed to meet people's needs. A new staff member who would lead on supporting people to take part in interests and hobbies had been appointed and was due to start work shortly.

Care staff told us and records confirmed that the provider had an effective recruitment procedure in place. This meant that care staff that were employed had been subject

Good

Is the service safe?

to checks to confirm they were suitable to work at the home. We saw evidence that when unsafe care was provided the provider took action through its disciplinary procedures.

People told us that they received their medicines. One person said; “They bring my medicines to me. It is very good”. Another person told us; “I have cream on my legs. They [staff] do it every day in the morning and the evening”. Medicines were stored at the correct temperature and in a secure cupboard. We observed a care staff member administered medication and saw this was done correctly. The staff member made sure each person had the correct medicines and then signed the medication administration record (MAR). People were supported in a kind manner to take their medicines and were always offered a drink. People that were prescribed pain relief were offered it. Where people were prescribed ‘as required’ medication a protocol was in place. This provided staff with the information to administer this medicine in a consistent way. Staff told us and records confirmed that all the senior staff were trained in managing medicines. This process included an assessment of their competency to administer medicines.

Requires Improvement

Is the service effective?

Our findings

At our inspection in June 2014 we asked the provider to make improvements in the care and welfare people received Regulation 9 and in the way care records were maintained Regulation 20. They sent us an action plan that told us how they were going to improve the service. On this inspection we saw that improvements had been made.

We checked whether the provider was acting in accordance with the provisions of Mental Capacity Act 2005 (MCA). The MCA assumes everyone has the capacity to make decisions and that people should be helped to make decisions. Some people may have been helped to understand things through the use of alternative techniques such as pictures and symbols but we did not see any of these in use. Where people cannot make decisions for themselves the MCA sets out the actions that must be taken to protect people's rights. Although there was information to indicate the people who were significant to the person and should be involved in important decisions there was no evidence that mental capacity assessments were in place to determine people's ability to make the decision. Where people were not able to make the decision we did not see a best interest decision had been made. For example people who were living with dementia were using bedrails and there was no mental capacity assessment in place to show the decision had been made in their best interest. Not all care staff were trained in the provisions of the MCA and care staff we asked incorrectly believed that relatives could make decisions on behalf of a family member. This meant that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the acting manager following the inspection and they told us an audit they had completed showed staff were not following the MCA provisions. They had put a training programme in place to develop the knowledge of the care staff. The peripatetic manager was fully aware of the provisions of the Deprivation of Liberty Safeguards (DoLS). They confirmed that no one living at the home was subject to a level of supervision and control that may amount to deprivation of their liberty.

Staff were provided with support and training to undertake their role. Comments from people that lived at the home and relatives confirmed staff had the knowledge and training to provide people's care. For example one person said; "They [care staff] look after me. I'd recommend it". A relative said; "[Relative's name] is getting good care". Newly appointed staff received induction training. Staff told us that this included a short two day period to get to know the environment, internal policies and procedures as well as training based on national care standards that was completed over a three month period. We also saw all agency care staff completed a short induction when they first worked at the home and that the provider checked they had the necessary training to provide people's care.

Care staff we spoke with confirmed they completed a range of basic training every year. The training matrix confirmed most staff were up to date with this training and action was taken to address any gaps in training. The provider told us that staff's competency and understanding of training was checked during individual supervision sessions and they were asked to identify how this had improved their care practices.

The provider had put in place a clinical facilitator whose role was to support staff to develop their knowledge and skills to improve the standard of care people received. The provider also confirmed that the organisation had joined the local care employers' organisation that provided a range of training and support. This gave them access to training based on 'good practice'. We saw evidence that some staff were due to attend continence training through this organisation. A notice we saw in the office confirmed that the provider was seeking care staff to act as champions in dignity, infection control, nutrition and moving and handling. Champions are staff that have extra training and act as role models for other staff and actively promote good practice in their specific field.

People had sufficient food and drink although people gave us mixed views about the standard of the food. Some people told us they enjoyed the food and had seen a significant improvement in the quality and in the choices on offer. A relative who was a regular visitor to the home told us; "I know [relative's name] is well fed". Other people were less satisfied with the quality of the food. One person said; "The food is up and down. The cooking is not good. It needs to improve". We saw that the provider had taken action to address people's concerns to improve the choice and standard of food. A new chef had been appointed and minutes of a residents' meeting showed that people had

Requires Improvement

Is the service effective?

been consulted about the food and had contributed to the menus. We also saw that there was a book where any comments about food were written and fedback to the chef. Unfortunately on the day of the inspection the chef was unavailable and this had affected the choice and standard of meal available.

We spent time observing at breakfast and lunch. We saw there were choices of food and drink and if people did not like a meal we saw they were offered an alternative. Throughout the day we saw that people were provided with plenty of drinks; both hot and cold. We saw staff were available to support people to eat and drink. However for some people the breakfast experience could be improved. We observed that people who arrived later for their breakfast sat at tables that contained the previous occupants' dirty crockery.

Records confirmed that people's nutritional needs were assessed and if needed a specialist diet was provided. For example one person required a soft diet and we saw this was provided. People's weight was regularly checked and we saw evidence that when people's weight changed significantly action was taken to involve health professionals.

People had their health care needs attended to. One person told us; "The GP comes to visit and sometimes the optician comes. The staff will contact the GP for me." This was confirmed by another person who told us; "If I am poorly they call the doctor". Care staff we spoke with knew people's health care needs. Records we saw confirmed that people received healthcare checks. For example records confirmed that people could receive eye checks from a visiting optician and that a chiropodist provided nail care. Currently there was no provision for a dentist to visit the home. The provider told us that this had been addressed and a dentist had been appointed to visit people. One person's care we checked needed support to maintain a healthy skin. We saw they needed their position changed during the day and they were checked regularly by a district nurse. We spoke with two health care professionals who confirmed that care staff made appropriate health referrals. One told us that when staff identified concerns about a person's skin they immediately contacted the service for support including the provision of pressure relieving equipment.

Requires Improvement

Is the service caring?

Our findings

People were overwhelmingly happy with the regular care staff and found them caring. One person said; “[The staff] look after me. Some staff are very good; on the whole you can’t complain”. Another person said; “I find everyone is kind and friendly”. We saw people were treated kindly. We observed care staff chatting and laughing with people and saw there was a relaxed and friendly atmosphere. We saw that care staff provided support in a relaxed manner and people were not rushed. For example at lunchtime we saw care was provided in a relaxed and sensitive manner. Care staff asked people if they needed help to cut up their food and advised them that food was hot. This demonstrated that care staff were concerned about people.

People told us staff asked them about their care. For example we saw people being offered a choice of food and drink and people told us they could decide when to get up and go to bed. We also saw records showing that people made decisions about their care. For example we saw that one person who had fallen from their bed was consulted about how to lessen the risks to them. The person did not want bedrails and an alternative method to keep them safe was agreed with them. Another person following a discussion decided not to have a flu inoculation. One person told us they made all the decisions about their care. They said; “They listen to me and [the care staff] do it as I want it”.

We spoke with relatives that visited the home regularly. No one expressed any concerns about their family member’s care. One told us; “[Relative’s name] is getting good care.”

Another one said; “The staff care about the people [that live here]”. They all told us they felt welcomed to the home and could visit when they wished. They told us that the care staff kept them informed about their relative’s care and involved them in decisions appropriately.

A health care professional we spoke with said that the care staff were helpful and promoted people’s privacy and dignity. We observed that people’s privacy was promoted. For example one person told us how they always kept their bedroom door locked. Other people told us they had health care treatment in private. Care staff we spoke with told us they always knocked on people’s bedroom door and sought permission before entering. This was confirmed by people we spoke with.

We observed that people’s independence was promoted. One person said; "They help me get dressed and washed. I try and do as much for myself as possible”. We saw some occasions when people’s dignity may be compromised. Two people expressed concern that they were occasions when they could not wear their own clothes because they had not returned from the laundry. We saw one person wearing another person’s trousers although these were changed later when the person’s own were found. One person told us they were unhappy because they were sleeping in their underwear due to lost clothes. Another person said; “Laundry here is terrible. I wear the same clothes, awful, awful, and awful” and “It is not right. Quite a few clothes are not mine”. We raised this with the managers and although they had taken action the problem was still not resolved.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of care were not meeting people's individual needs. Some people were very pleased with the care and told us it met their individual needs. One person said; "They look after me alright. I'd recommend it". Some other people told us there were times when care was not provided promptly and they had to wait for care. One person told us; "I am waiting to have my hair done. I am uncomfortable sitting in this wheelchair". These mixed views corresponded with what we observed during the inspection.

We saw there were times when care was task focussed rather than responding to people's individual needs. For example we saw people sitting in their wheelchair waiting to be supported to move into easy chairs or to use the toilet. Care staff we spoke with said it was their role to hoist people and we saw this was done for people in succession. This meant that care for these people was not meeting their individual needs. Some people told us that staff did not respond promptly to attend to their needs. One person said; "I dislike waiting. Here I wait a lot. The response time to the buzzers should improve". We did not see during the inspection that people waited excessive periods.

People were not adequately supported to take part in meaningful activities or to have appropriate social stimulation. One person told us; "There is not much going on". Although some people were encouraged to follow previous interests and some social activities took place, we observed that some people were left for lengthy periods with no stimulation. Information in people's records did not always show people's preferences and there was no evidence to show that people's previous interests or hobbies were regularly taken into account when planning things to do. People living with dementia were not well supported. We observed that people who sat in one lounge had little stimulation apart from the television being on. People were left for lengthy periods with little staff interaction. Interactions with staff that took place mainly related to practical care tasks such as being supported to have drinks. We did not see staff taking these opportunities to engage in meaningful interactions with people. There were no objects available to stimulate people's interests and senses.

This meant that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that a staff member specifically appointed to support people to take part in hobbies and interests was due to start work at the home. Information in the PIR stated that there were plans to provide support to people living with dementia to attend a community cafe.

Care staff we spoke with were able to tell us about people's individual care needs and how they liked their care provided, and about things and people that were important to them. Care staff for example were able to describe how one person with specialist communication needs expressed their wishes non verbally. We also saw evidence that people's individual wishes were responded to. For example one person requested a female care staff member to provide their personal care and this was provided. Another person needed support due to a risk of falls. This person was involved in decisions about their care and their individual wishes were acted upon. Some people needed specialist support for example to maintain a healthy skin. We saw each of these people had care that met their needs.

People's needs were assessed before they moved to live at the home. The assessments were evaluated every month to make sure they were up to date. People had individual care plans based upon their assessment that outlined their care needs and how these should be met. Plans contained some information about people's likes and dislikes. The provider had put in place a handover system that made sure that each people's needs were discussed at the end of every shift. This meant that care staff had the very latest information about everyone's care needs.

People said they would raise concerns with the staff and were confident that staff would try to deal with them. Several people told us that the unit manager was very approachable and would always respond when they raised issues. One relative told us; "If I had a problem I would raise it with [staff name]". Another relative said; "I would speak on my relative's behalf. [Staff member's name] would deal with it". The provider had a complaints procedure in place. This was displayed in the home. We saw that records of formal complaints were kept and that these were fully investigated and responded to. We were told that some

Requires Improvement

Is the service responsive?

people had raised concerns about the standard of the laundering of clothes but there was no information about this issue in complaints record. The acting manager informed us that previously these issues were recorded separately as comments and grumbles but were now being recorded and acted upon in the same way as more formal complaints. This meant that information would be clearly available to show how all issues of concern had been responded to.

Requires Improvement

Is the service well-led?

Our findings

When we completed our last inspection in June 2014 the provider needed to improve the way it assessed and monitored the quality of care. They sent us an action plan telling us the action they would take. On this inspection we saw that actions had been taken but further improvements were needed.

There has not been a registered manager in post since January 2014. The provider had made us aware of the actions they had taken to appoint a manager. During this period three temporary managers had been in post. The current temporary manager has been working at the home since August 2014. A clinical facilitator was working at the home supporting the staff to improve and develop their skills and knowledge. During the same period the provider has changed the regional manager three times.

Some of the people and relatives we spoke with told us they were unsure of the management arrangements of the home. They told us this was because they had seen a number of different senior staff members. One person said; "I don't know who's in charge". We saw the provider had taken action to try and clarify this for people and people told us they had seen the current manager but were unclear of their role. Relatives told us that although they had seen some improvements since the current manager was in post they wanted a permanent manager to provide consistency of care and continued improvements.

The provider completed a range of checks and sought the views of people that used the service and their relatives. Some of these had not been effective. For example the provider's checks had not identified that care was task focussed and was not consistently responsive to people's needs. We also saw that people had raised concerns about the level of activities and the quality of the laundry both in the annual satisfaction survey reported on in June 2014 and at a resident meeting in July 2014. The action taken by the provider had not addressed these concerns.

The current acting manager although at the home on a temporary basis was proactive in developing and improving the home. For example staffing levels had been increased to meet people's needs, action was taken to improve the meals including introducing a snack box for each person. The provider was also taking action to improve the environment. We saw that action plans were in place showing areas for future development.

Care staff we spoke with told us that the current management encouraged them to develop their knowledge and skills including completing recognised qualifications. We also saw that care staff meetings had been introduced as well as a weekly regular communication briefing. Care staff told us they would have no hesitation in raising concerns about care practices with either the unit manager or the acting manager and were confident that action would be taken.

Providers have a responsibility to inform the Care Quality Commission (CQC) of important events that occur in the service. The current manager of the home had informed the CQC of significant events promptly. This meant that we could be sure that the provider had taken the appropriate action.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care A registered person must carry out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user and design care or treatment with a view to achieving service users' preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.