Bondcare (London) Limited

Springfield Care Centre

Inspection report

Springfield Drive
Ilford
Essex
IG2 6PS

Tel: 02085189270

Date of inspection visit:
28 August 2018
29 August 2018
05 September 2018

Date of publication:
17 October 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Springfield Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Springfield Care Centre can accommodate 80 older and younger adults who may have dementia in a purpose built three storey building. People were accommodated across six units on the ground and first floor. At the time of this inspection, 72 people were using the service.

This inspection took place on 28 and 29 August and 5 September 2018. The inspection was unannounced. This was the first inspection since the service was registered under the provider Bondcare (London) Limited in July 2017.

The service did not have a registered manager. 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 service is run. At the time of this inspection there was a manager in position who had applied to become registered with CQC.

There were enough staff on duty to meet people's needs but occasionally the service was short staffed. Recruitment checks were carried out before new staff began working at the service. People had risk assessments carried out to mitigate the risks of harm they may face and were protected from the risks associated with the spread of infection. There were systems in place to manage medicines safely. Building safety checks were carried out in line with building safety requirements. The provider used accidents and incidents to make improvements to the service.

People's care needs were assessed before they began to use the service to ensure the provider could meet their needs. Staff received training and were supported with supervisions and appraisals to help them to carry out their role effectively. The provider had systems in place for staff to be updated on people's well-being and changes in care needs. The layout and décor of the building could be confusing for some people to find their way around. The provider was in the process of refurbishing the building. People were supported to eat a nutritionally balanced diet and to maintain their health. The provider understood their responsibilities under the Mental Capacity Act (2005). Staff understood the need to obtain consent before delivering care.

Staff described how they developed caring relationship with people. People and their relatives were involved in decisions about the care. The provider had a system in place where each person had a named nurse and care worker who had overall responsibility for the person's care. There was a 'resident of the day' system where each person had a day dedicated to them to make them feel special. Staff were knowledgeable about equality and diversity. People were supported to maintain their independence and

their privacy and dignity was promoted.

Care plans were personalised, contained people's preferences and were reviewed monthly. Staff knew how to deliver a personalised care service. People were offered a variety of activities and their communication needs were met. Complaints were dealt with appropriately and compliments were recorded. People's end of life care preferences were recorded.

People, relatives and staff gave positive feedback about the leadership in the service. The provider had a system to obtain feedback about the service in order to make improvements. People, relatives and staff had regular meetings so they could be updated on service development and make suggestions for improvements. The provider had quality audit systems in place to identify areas for improvement. However, call bell response times and care plan checks were not taking place at the time of inspection.

We have made two recommendations in relation to the refurbishment of the building and quality assurance systems.

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. Staff were knowledgeable about reporting abuse and whistleblowing.

There were enough staff on duty to meet people's needs but occasionally the service was short staffed. The provider had safe recruitment procedures in place.

Risk assessments were carried out to mitigate the risks of harm people may face. Building safety checks were carried out. Accidents and incidents were recorded and lessons were learnt from these.

People were protected from the risks associated with the spread of infection. Medicines were managed safely.

Is the service effective?

Good

The service was effective. People had their care needs assessed before they began to use the service. Staff were supported to carry out their role with supervisions, appraisals and training.

People were assisted to meet their nutritional needs and were offered choices of food and drink. Staff assisted people to maintain their health.

The provider had systems in place for the staff team to share people's changes in need. The layout and decor of the building meant some people could have difficulty finding their bedroom. The provider was in the process of refurbishing the building.

Care was provided in line with the requirements of the Mental Capacity Act (2005). Staff understood the need to obtain consent before delivering care.

Is the service caring?

Good

The service was caring. Staff explained how they got to know people and their care needs. People and their relatives were involved in decisions about the care.

Each person had a named nurse and care worker who had overall responsibility for their care. The provider had a system in place where each person had a day dedicated to them where they had the opportunity to have a special meal and activity.

Staff knew how to provide an equitable service. People's privacy, dignity and independence was promoted.

Is the service responsive?

Good

The service was responsive. Staff understood how to provide a personalised care service. Care plans were personalised, contained people's preferences and were reviewed monthly.

People were offered a variety of activities to meet their social needs. Care plans included people's communication needs.

The provider kept a record of compliments and complaints and these were used to make improvements to the service.

People had their wishes documented for end of life care.

Is the service well-led?

Good

The service was well led. The manager was in the process of becoming CQC registered. People, relatives and staff gave positive feedback about the leadership in the service.

The provider was in the process of receiving completed feedback surveys so they could use these to make improvements to the service.

People, relatives and staff had regular meetings so they could be updated on the development of the service and make suggestions on how to improve the quality of care.

The provider had quality audit systems in place in order to identify areas for improvement. However, audits for call bell response times and care plans were yet to be implemented.

The service received positive feedback from the local authority for their willingness to work jointly with them.

Springfield Care Centre

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 28 and 29 August and 5 September 2018. The inspection was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor 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.

We usually ask providers to complete a Provider Information Return (PIR) before we inspect to tell us what the service does well and improvements they plan to make. However, due to technical problems a PIR was not available and we took this into account when we inspected the service.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority with responsibility for commissioning care from the service to seek their view about the service.

During the inspection we spoke with 15 staff which included the regional support manager, the manager, two deputy managers, four care workers, four nurses, an activities co-ordinator, the maintenance person and the chef. We also spoke with six people who used the service, three relatives and a visiting health professional. We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed eight people's care records including risk assessments and care plans and reviewed eight staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Good

Is the service safe?

Our findings

People and relatives gave us mixed feedback about the service being safe. One person told us, "I feel safe although I feel that the staff are a bit rushed. There is not enough staff." Another person said, "I don't feel safe. The [care staff] are not helpful. Sometimes there are not enough carers." A third person told us, "I feel safe. The staff know how to look after me." A relative told us, "Overall, I feel that [person using the service] is safe." Another relative said, I am happy with the [person's] care."

Care staff told us there were enough staff on duty except if staff called in sick at short notice. A nurse told us, "Yes there is enough staff. There could be a strategy if staff cancel shifts or go sick. Sometimes they phone at seven (o'clock) to say they are not coming in when their shift starts at eight (o'clock)." A care staff member said, "Not always. [We] use agency because we don't have enough staff." Another care staff member told us, "Most of the time there's enough. Sometimes [staff] cancel in the morning and we are short staffed but most of the time there's enough."

The management team told us there were currently four staff vacancies which they were in the process of recruiting to. The service used bank staff and agency staff to cover staff absences. We discussed staffing levels with the regional support manager and the manager who told us they were planning on reconfiguring the six units into four units which should help with the deployment of staff. They also told us they continuously reviewed staffing levels to take into account changes in people's needs.

We checked the staff rotas and saw during the daytime there were four nurses and 19 carers and at night there were two nurses and nine carers working with the 72 people using the service. Care plans included a dependency assessment to enable the provider to know the numbers of staff needed. During the inspection, we noted people were responded to in a timely manner when they asked for assistance or pressed their call bells. This meant there were enough staff on duty to meet people's needs.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. Staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had provided written references. New staff had undergone criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates to check their continued suitability. This meant a safe recruitment procedure was in place.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK and ensures nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards.

The provider had safeguarding and whistleblowing policies which gave staff clear guidance on what to do if they suspected a person using the service was being abused. Staff had received training in safeguarding adults. The management knew how to handle safeguarding concerns and had appropriately notified the local authority and CQC.

Staff were knowledgeable about reporting safeguarding concerns and whistleblowing. One staff member told us, "You need to report to your line manager. In the case of no action taken you take it [safeguarding concern] to head office. You start with [reporting to] the nurse then your line manager. You say something to the manager and if [I have] not heard [the outcome] I take it further." Another staff member said, "Speak to the nurse, speak to line manager. Someone informs local authorities about the concern they've come across. If the nurse or the manager was doing something wrong I would tell the LA [local authority]." A third member of staff told us, "Basically you grass [inform] on people when you see them doing naughty stuff." This meant the provider had systems in place to protect people from the risk of abuse.

People had risk assessments carried out so that measures could be put in place to keep them safe. Each person had a personal emergency evacuation plan. Risk assessments were carried out on admission for falls, skin integrity, moving and handling, call bells, nutrition, restraint and bedrails, medical conditions and medicines. One person's nutrition risk assessment stated, "[Person] is at a high risk of malnutrition. [Person] is on soft diet and normal fluids. [Person] is able to eat and drink himself and a fortified meal is offered. Meals and drinks are offered in a pleasant and relaxed environment at all times e.g. light music is played during mealtime." This meant the provider took steps to mitigate the risks of harm to people.

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, the five-year electrical installation checks were carried out on 15 December 2016, portable appliance testing (PAT) was completed on 9 August 2018 and the gas safety check was carried out on 27 October 2017. The service had a fire risk assessment which was updated on 14 December 2017, fire safety equipment had been serviced on 23 October 2017 and the most recent fire drill was carried out on 9 August 2018.

The provider had a comprehensive medicines policy which included clear guidelines to staff about medicine administration, ordering and receiving stocks of medicines and record keeping. People's medicines were stored in locked cabinets or trolleys in a locked room on each floor. Staff checked the temperature of the room and the medicine fridge daily and these were within the correct range. Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

Medicine administration record (MAR) sheets had been completed and signed with no gaps to indicate people had received their medicines as prescribed. People who required their medicines to be given covertly had guidelines on how to safely administer the medicine and signed agreement by the GP. Covert medicines are those that need to be given in a disguised format because the person lacks the capacity to understand why the medicine is needed.

People who required 'pro re nata' (PRN) medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. However, we found records for one person on PRN for pain management did not have their guidelines updated to reflect a change in PRN medicines prescribed by the GP. Records showed this change had taken place within the last few days and the nurse in charge took immediate action, replacing the old guidelines with an up to date protocol. Reasons for giving PRN medicines were documented on the back of the MAR charts.

The provider kept a record of medicines in stock. We checked the amount of medicines in stock against the records and found one error. One person's box of tablets was recorded as 28 tablets received on delivery when it was actually a box of 30. This meant the number of tablets in stock was two more than indicated in the records. We discussed our findings with the management who told us they were confident the issues

with the missing PRN protocol and the stock count would be picked up by the nurses during the weekly medicines audit. This meant the provider had systems in place to manage medicines safely.

People were protected from the risks associated with spread of infection. The provider had an infection control policy which gave guidance to staff about the steps they should take to prevent the spread of infection. Staff confirmed they were provided with sufficient personal protection equipment such as gloves and aprons. The service had adequate hand washing facilities including hand soap and paper towels. The provider employed domestic staff to keep the premises clean.

The provider kept a record of accidents and incidents which included the action taken to prevent reoccurrence. For example, an incident occurred where a person using the service was not in their bedroom. The building and surrounding garden area was searched, and the person was found outside the gated garden area. One of the actions noted was the maintenance person was asked to ensure latches were fitted on all the garden gates to prevent people wandering into the street and being harmed. This showed the provider had systems in place to learn from accidents and incidents in order to improve the service.

Good

Is the service effective?

Our findings

People had their care needs assessed before they began to use the service, so the provider could be sure people's care needs could be met. This was followed up by a more detailed assessment once the person started to use the service. Records showed people's assessment included mobility, personal care, communication, nutrition and hydration, skin integrity, cognition, behaviour, socialisation, medical history, medicines list, equipment needed and palliative care needs. An additional assessment was carried out for people with dementia or mental health needs. People's care preferences were also documented in the assessment. For example, one person's assessment stated, "[Person] does not mind who supports [them] with personal hygiene needs male or female. [Person] usually wakes up and washes between 5am and 6am. [Person] is able to make decisions about [their] care." This meant people's needs were assessed and important information about the person could be captured to ensure the service could meet their needs.

Staff confirmed they had opportunities for training and found this useful. One staff member told us, "Yes. I did nutrition with the pharmacist. They came in April or March [2018]. I had to do a test." Another staff member said, "Yes. [I have had] two trainings this year. Will be more coming up soon." A third staff member told us, "Yes every six months. We do e-learning. If there is anything we don't know the nurse will explain to me. It's very good."

The training matrix showed staff received training including in safety related subjects such as fire safety, food safety, health and safety and moving and handling. New staff received a three-day induction which included completing e-learning in subjects such as record-keeping and person-centred care and a practical session in moving and handling. The manager told us that new nursing staff shadowed more experienced nurses for three days and new care staff shadowed more experienced care staff for two days. The manager also told us new staff could shadow for more days if needed. Staff had the opportunity to do the Care Certificate to increase knowledge. The Care Certificate is training in a set of standards of care that staff are recommended to receive before they begin working with people unsupervised. This meant people were supported by suitably qualified staff.

Staff told us they were supported with supervisions to help them to carry out their role effectively and they found them useful. Responses included, "Very useful" and "They are useful as they give understanding." Records showed topics discussed in supervisions included attendance, person-centred care, staff rota, meal experience, choking risks, electronic record keeping and skin care. The provider was in the process of completing annual appraisals for staff. Records showed appraisals were used to review the staff members performance over the past year and to set goals for the forthcoming year.

During the inspection, we observed lunch on the different units. One person using the service after tasting their meal stated out loud emphatically how good the food was. Another person told us, "The food could be improved. Meat is inclined to be tough. The chicken curry was not well done. The soup is very nice." A third person said, "I have a special diet. The food is mediocre. I came from a specialist home where the food was much better. I don't get a choice and don't eat a lot."

One relative told us, "Staff seem surprised that [person] eats all her meals." Another relative said, "There is a lot of fried stuff or minced meat."

Staff confirmed that people had choice of the food and drink they consumed. One staff member told us, "Yes they do. There are menu choices. They can also order according to what they want." Another staff member said, "Sometimes we present the food on the menu – we'll read out the food on the menu and they'll say which ones they like." A third staff member told us, "Yes we offer everything. Ice cream, fruit, yoghurts. Some have rice and curry chapati, vegetarian. Different sauces."

We checked the kitchen and observed it was well stocked with a variety of nutritious food. The service used a nutritious four-week menu and people made their choices the week before. The chef told us people could change their mind on the day and choose an alternative. Menus contained a variety of dishes with a choice of cereals, toast or a cooked breakfast and two choices for lunch and dinner. The chef was knowledgeable about people's dietary requirements and attended the meetings for people using the service and their relatives in order to get ideas for meals. This meant people's nutritional needs were met,

Staff gave positive feedback about communication within the staff team. One staff member told us, "Immediate change in need is communicated by [the] nurse but often the carer finds out first. For example, someone's behaviour might change. As a carer we might say [person] is experiencing this change. The nurses listen to us." Another staff member said, "I would say that is quite good. Between the team you [are] informed." A third staff member told us communication had improved since the move to electronic care records. This staff member said, "The information is on the [electronic handheld] device. This one is very good. The paperwork used to take so much time, but this is quick, quick, quick. The nurse will tell me [about changes] and we do handover." This meant people whose needs changed could be reassured that this would be communicated within the staff team.

People were assisted to maintain their health. A visiting health professional told us, "It's always been good, always a nurse to speak to. [Nurses] are helpful. They offer to stay in the room with you. I've never seen anything untoward." One staff member told us, "By offering a proper diet and helping with their personal hygiene. For those who can't communicate their needs we also work out the way we can communicate. We view them as an individual." Another staff member said, "It's about stepping into their shoes. If there is any sign they are not well, the nurse is informed."

The provider had arrangements in place for the GP to visit weekly and if they could not come due to annual leave, the clinical pharmacist from the GP surgery visited the home. Care files showed a record of visits from healthcare professionals and the outcome. For example, records showed people had access to a psychiatrist, the community mental health team, tissue viability nurse, nutrition nurse, optician and dentist. Where appropriate care plans showed people had their temperature, blood pressure, pulse and breathing checked monthly to help monitor their health. People had health specific care plans in place suitable for their health conditions including catheter care, nasogastric intubation (NG) feeding tube and percutaneous endoscopic gastrostomy (PEG) tube. NG feeding and PEG feeding are medical interventions to help people who are nil by mouth to receive adequate nutrition and hydration.

The building was purpose built across three floors. The kitchen, laundry room and staff room were on the top floor. People's bedrooms and the communal areas were laid out across six units on the ground and middle floor. The management team told us they were in the process of refurbishing the whole building and reducing the number of units from six to four with two on each floor. Minutes of meetings showed this was the case and following the inspection the regional support manager sent us a summary of the refurbishment plans. This included looking at ways to decorate the lounge in the dementia unit to give a feeling of being

outdoors using flowers, birds and butterflies on printed wallpaper or pictures on the walls or by using flowers in window boxes. Another plan was to hang new art work throughout the home which had been purchased to make the building feel more homely.

We observed that flooring had been replaced for hard flooring which would make it easier to maintain hygiene levels. Some corridors had been painted to brighten them up and the plan was to paint the other corridors. However, the layout and decor of the building was confusing to people with dementia or poor eyesight because all the corridors and doors to rooms were the same colour. This meant it was difficult for people to find their bedroom.

We recommend the provider seek advice and guidance from a reputable source about refurbishing the home to meet people's needs.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of this inspection there were seven people with legally authorised DoLS and 17 people awaiting a decision because they required a level of supervision that may amount to their liberty being deprived. Records showed assessments and decision-making processes had been followed correctly.

Records showed staff received training in the MCA and DoLS. Staff demonstrated they were aware of what these were. One staff member told us, "MCA is [people's] capacity to make decisions, at a particular given time. Capacity assessments are done prior to [person] coming in." Another staff member said, "MCA is when someone is not able to make their own judgement, someone else will act on their own behalf. It can be financial or for health." This staff member explained DoLS was, "Where you deny someone their liberty and you should not do that unless you are keeping them safe. "

Staff were knowledgeable about the need to obtain consent before delivering care. One staff member told us when they needed to obtain consent and said, "All the time you do anything for them. If you give them personal care explain to them what you're about to do." Another staff member told us, "Always we ask, when we change their dress and food also. Always give a choice." A third staff member said, "[I ask for consent] for what they would like to wear, how they would like their hair to be combed, to the food that they want." People with capacity had signed their consent to receive care and treatment at the service. This showed the provider had systems in place to work within the requirements of MCA and DoLS legislation.

Good

Is the service caring?

Our findings

People and relatives gave us mixed feedback about the staff being caring. One person told us, "Carers are quite kind. Nurses are good." Another person said, "Some carers are more caring than others. The staff are a bit rushed and don't get time to talk to me." A third person told us, "Some carers are caring, others are not. If I ask to go back to bed I'm told 'no'." One relative told us, "I feel that they [staff] are caring." Another relative said, "I don't feel confident about [person's] care. [Person] is left in bed."

The was a calm, relaxed and happy atmosphere throughout the home on all inspection days. Staff including the maintenance person were seen chatting and laughing with people. We observed positive interactions between people and staff. For example, during lunch a staff member explained to one person who was confused the choices for dessert. The staff member was patient, took the time to explain the choices and to wait for a response. The person chose ice cream.

Staff described how they got to know people's care needs. One staff member told us, "Once they came in we get the history from relatives, GPs, social workers or any other person who is in their lives. Once we get that, we get the info from the person themselves." Another staff member said, "You introduce yourself, you try to find out what they like to be called, what they like to eat and drink. [We get to know them] through chatting to them and also from the information supplied from where they have come from." A third staff member told us, "Mainly talking to them. We also read their care plans." This meant care was provided to people by staff who knew what assistance they required.

The service had a keyworking system which meant each person using the service had a named nurse and a keyworker. The keyworker is a named care worker who has responsibility for ensuring the wardrobe is tidy and all the resources are there to meet the person's needs such as clothing and toiletries. The named nurses took responsibility for care plan reviews, liaising with the family and health professionals, making referrals and diet notification to the kitchen.

The provider also had a 'resident of the day' system in place where four people using the service each day were made to feel special. On this day, the activity co-ordinator spent time with the person and asked them what they wanted to do that day. The maintenance staff member spoke to the person to find out if any maintenance work was needed in their bedroom and the chef asked the person what special meal they would like to eat on the day. The person's care plan was reviewed on the day and relatives were invited.

People and their relatives were involved in decisions about the care provided. The manager told us, "It starts from care planning. We involve residents and relatives and we personalise the care plans from what they tell us. I believe it's being on the floor, talking to [people who use the service] and listening to [them] in case they need to bring up any complaints." The deputy manager told us, "[At the assessment] we sit with them [person using the service], discuss with them and wait for their answer. The family is involved."

Staff confirmed how people and their relatives were involved in the care. One staff member told us, "We always have a social work review in case of any changes and the family is informed." Another staff member

said, "That is done through the meetings they have, with the manager present."

The provider had an equality and diversity policy which gave clear guidance to staff about providing an equitable service. Records showed staff received training in equality, diversity and inclusion. The manager explained how they ensured people were treated fairly and equally. She told us, "We look at individual needs. For residents who speak a specific language, we identify staff who also speak that language and we bring them together. We talk about it [equality and diversity] in staff meetings and supervisions." Staff were knowledgeable about providing an equitable service. One staff member told us, "We make sure we treat them with respect. It doesn't matter their ethnicity. We provide protection as well. We protect them all the time from different and various things." Another staff member said, "We treat [people] equally and fairly by treating everyone as an individual." A third staff member told us, "It is the same thing as taking them as individuals and is according to their needs."

The manager and staff explained how they would support people who identified as being lesbian, gay, bisexual or transgender (LGBT). The manager told us, "I believe it will start with assessment, making sure we respect them [people who identify as LGBT]. We will look after them according to their needs and wishes." Responses from staff included, "I would treat them as a person and as an individual", "The care would not be different" and "By just encouraging them to be themselves. We live in a modern society now, so everybody has the right to be who they want to be." This meant staff were aware of equality and diversity.

People's privacy and dignity was promoted. The provider had a policy which gave guidance to staff about promoting people's privacy and dignity. During the inspection, we observed staff promoting people's privacy and dignity. For example, we saw one staff member assisted somebody to the bathroom and then waited outside to give them privacy until the person was ready to be assisted again.

Staff knew how to promote people's privacy and dignity. One staff member told us, "You've got to knock on doors before going in. You've got to make sure doors are closed, curtains are drawn." Another staff member said, "We make sure we take [person] to a private area to protect their dignity. If the [person] is in their room we still close the curtains, even on the first floor." A third staff member told us, "Close the door and close the curtain. If anybody comes they have to knock the door. We cover them with a towel."

Staff described how they encouraged people to maintain their independence. One staff member told us, "Well, if someone can't use one hand try and get them to use the other hand. Let them do as much as they can. If not [then] you help." Another staff member said, "By trying to help them do things independently and support them in the process." A third staff member told us, "By encouraging them. They get excited when they can do more for themselves." This meant people were assisted to maintain their independence.

Good

Is the service responsive?

Our findings

Staff demonstrated an understanding of delivering personalised care. One staff member said, "It's according to [person's] likes and needs not [according] to anyone else." Another staff member told us, "The care is centred around the person." A third staff member said, "That care is based on that individual alone."

People and their relatives were involved in their care plans which were reviewed monthly. For example, one person's care plan review held on 11 July 2018 stated, "I discussed with [person] about his care plan as he has the capacity to make decisions. [Person] said he is happy with the care he receives at Springfield and he does not want to make any changes." Another person's care plan review carried out on 6 June 2018 stated the relative was happy with the care the person received.

Care plans were personalised and contained people's preferences. One person's care plan stated, "[Person] feels angry when people have bad manners" and "[Person] likes to listen to music on the radio in his room." Each person had a social profile which indicated their personal history details, significant events and working life, interests, favourite newspaper and favourite foods. This meant staff understood how to provide personalised care.

We asked the manager what they had done to implement the Accessible Information Standard (AIS). The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. The manager told us they were aware of the standard but had not yet done anything to implement it. The regional support manager and the manager told us if anybody came to the service who needed accessible information they would make sure this was arranged. The manager told us for people with a sight or hearing impairment they would take the following actions, "Maybe using braille. Talking [information] through with [person]. Can do audio. Some [people] use the hearing aid. Making sure the hearing aid is in good working order. Using pen and paper. Maintaining eye tests and hearing tests."

Each person had a communication care plan. One person's care plan stated, "Able to communicate at times very confused and disorientated." Another person's care plan stated, "[Person] is able to converse and make her needs known. She wears hearing aids in both ears and needs assistance. She wears glasses for reading only." This meant people's communication needs were met.

There were two activity co-ordinators employed by the service. One activity co-ordinator told us the hairdresser visited once a week and spent the morning in the hairdressing room and the afternoon doing people's hair in their bedroom. Regular activities included reminiscence. bingo, baking, music and singing, quizzes, board games, pamper days, flower arranging, skittles, darts, gardening and film club. The service had three outside entertainers a month. We observed an outside entertainer was at the service on the first inspection day. People's enjoyment was evident because they were smiling, clapping and singing along and the activity co-ordinator was encouraging people to get up and dance.

The activity co-ordinator told us they provided one to one activities weekly to people who stayed in their bedroom. These activities included hand massage, reading the newspaper, reminiscence and ball games.

We observed the activity co-ordinators helping care staff at lunchtime to assist people with eating. The activity co-ordinator showed us a laminated book of food pictures which they used to assist people to choose the food they wanted. We observed one person spent time in their bedroom painting. The manager told us once the redecoration of the home was completed they were going to give this person a section in the corridor for them to display their artwork.

Staff described the activities that were offered to people. One staff member told us, "We have musicians, we have church people who come in and as carers we can try to do activities that people can join in. Different faiths are catered for." Another staff member said, "There's an activity called bingo. Activity department will take them to religious things and they will come visit too. Some [people] go to temples."

The activity co-ordinator explained representatives from three religious groups visited monthly. There was an outside group that came in weekly to do an exercise session in the home. The activity co-ordinator explained this group were from a particular spiritual group and in addition to the exercise group would check in with the people using the service who were of the same religion. The activity co-ordinator also explained that they were able to arrange to take people to their chosen place of worship and had previously taken a person to the mosque before they passed away. This meant people's social and religious needs were met through the activities offered.

People and relatives knew how to raise a complaint. One person said, "I have no complaints with management. Staff are generally responsive." A relative told us they had made a complaint the day before and were waiting for the outcome.

Staff described the actions they would take if somebody was unhappy with the service provided. One staff member told us, "Go ahead with the complaint. I would refer them to the nurse. If it's something that I did, I would call another person to hear it." Another staff member said, "I would advise them to put it in writing and direct them to management." A third staff member told us, "Inform my nurse first thing then she would inform the deputy manager who will inform the manager."

The provider had a complaints policy which gave clear guidance to staff about the actions to take if they received a complaint. We reviewed the record of complaints and saw these had been dealt with appropriately with the actions taken documented. For example, one complaint was about the late delivery of mail. Actions taken included a new system being introduced where the administrator delivered letters individually to people rather than placing them in unit trays. The records showed the complainant was satisfied with the resolution. This showed the provider had a system in place to use complaints to improve the service.

The provider had a system of recording compliments received by the service. For example, we saw the service had noted a verbal compliment from a relative, "Thanking the nursing home for the care we gave [family member]." Another example was a card from a relative which stated, "Thank you for all the care you provided over the last two years to [family member]. We appreciate all that everyone did for him."

Staff told us they had received training in end of life care. One staff member told us, "Yes. It's a hard one. We have a pathway. We keep them comfortable. Their family might want them to die in the care home. Their needs are met, and we maximise comfort." Another staff member said, "Yes, it depends on what it says on their care plan. You get it from the nurse or sometimes they can tell you themselves." A third staff member told us they had done the training but so far had not needed to put their training into practice.

The service had an end of life care policy to give guidance to staff on how to provide compassionate care.

Records showed where appropriate people had a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) agreement in place which was signed by the GP and indicated a discussion had taken place with the relatives. People also had advanced care plans which indicated if the person followed a religion, where they wished to spend their last days and whether they had a lasting power of attorney. This meant people's end of care preferences were documented.

Good

Is the service well-led?

Our findings

There was not a registered manager at the service. The manager at the service had submitted their application to become registered with CQC.

People told us they liked the manager. One person said, "[Manager] is a nice woman." Another person told us, "Always able to talk to management." A third person said, "[Manager] says hello. Seems approachable." However, two people told us they did not know who the manager was. A relative said, "I have met the manager and the deputy. They seem ok."

The manager told us they were not aware of any staff equality issues and it was a, "Very diverse workforce. Staff told us they thought staff were treated fairly and equally. One staff member told us, "So far I've not seen [any staff] treated badly. Lots of staff from different places." Another staff member said, "Yes we are treated equally."

Staff gave positive feedback about the leadership. One staff member told us, "Yes I do feel supported. I can talk to anyone about things. Yes she [manager] is a good leader." Another staff member said, "We've had different managers, but I would say yes, she is a good leader." A third staff member told us, "[Manager] is very nice."

The manager told us, "I believe in having that relationship with staff, if you are approachable you can develop that relationship with them." The regional support manager added, "They've also got me now and I work very openly." This meant people, relatives and staff found management approachable.

The provider had recently distributed feedback surveys for people and their relatives to be completed to indicate how satisfied they were with the service provided. The survey questions included if people were satisfied with the time they got up, choices of food, drinks and snacks, bedtime, if staff treated them with respect, privacy, security, suggestions and complaints. At the time of the inspection, the provider was in the process of receiving completed surveys and planned to analyse them to create an action plan in order to improve the service.

The provider had a system of holding regular meetings for people using the service and their relatives. We reviewed the minutes of a 'residents and relatives' meeting held on 15 May 2018 and saw topics discussed included introduction of new home manager, refurbishment of the home, catering and activities. The manager told us the plan moving forward was to hold relatives' meetings every three months and meetings for people using the service every month. This meant people and their relatives could receive regular updates on the development of the service and make suggestions for improvement.

The provider had a system of holding regular staff meetings. Staff confirmed they had meetings and found them useful. One staff member said, "We had one in May, but we need another one. We can discuss things and implement and improve things by talking about them." Another staff member told us that staff discussed issues regarding the welfare of people using the service which meant people also benefited from

the meetings.

However, one staff member said, "It's rare that we have staff meetings but there's a regular staff meeting that does not involve carers. When they have those meetings, we feel left out." When we raised this with the manager she told us the staff member was probably referring to the daily flash meetings which were held every weekday morning. Representatives from all the departments attended the flash meetings to share significant issues and to maintain communication within the service. The manager explained that any information discussed at the flash meetings was then shared with the care staff in the afternoon.

We reviewed the minutes of the most recent general staff meeting held on 16 May 2018 and saw topics discussed included introducing the new home manager and the regional support manager, training, documentation, refurbishment of the home, staff recruitment and teamwork. The minutes indicated these meetings were to be held every three months. The manager told us the next meeting should have taken place in August but had been delayed due to annual leave.

Care staff meetings were held twice on the same day to enable as many care staff as possible to attend. We reviewed the most recent care staff meeting held on 30 May 2018 and saw topics discussed included shifts, documentation, sensor mats, uniform, training, escorting to hospital and infection control. The minutes of the most recent nurses meeting on 17 July 2018 showed topics discussed included care plans, medicines, the GP surgery, communication and handover, staffing, documentation, training and the role of the weekend site manager.

The regional support manager told us they were planning to start managers' meetings with the four care homes they managed so the managers could share ideas for improvements. This meant staff could receive regular updates on service developments and make suggestions for improvement

The provider had a quality audit system in order to identify areas for improvement. The nurse in charge on each unit completed a daily management report which detailed untoward incidents, new admissions, hospital transfers or discharges, incidents of falling or people becoming unwell, staff sickness and absence and concerns raised by people or their relatives. We saw these were up to date with no issues identified.

Medicines were audited weekly by the nurses and bi-monthly by management to check that people were receiving their medicines as prescribed. These were up to date and records showed management dealt with issues identified appropriately. The monthly weights management audit was up to date and showed when weight loss occurred this was discussed with the nurse on the unit to find out what action had been taken and whether a referral to speech and language therapy or the dietitian was needed.

Care plans were in the process of being transferred from paper format into an electronic format. At the time of this inspection, the service was using both systems until the transfer was complete. During this period of transition, care plans were not being audited. The management team showed us the care plan audit form they planned to implement once the care plans had been made electronic which would check required documentation was in place on a monthly basis.

We noted there was no call bell audit, for the management to monitor response times to call bells. The management team explained they had identified this as an issue and had requested new phone lines to be installed which would be attached to the call bells and would enable a printout or a computer view, so they would be able to check call bell response times. Records showed this was the case and they were awaiting an installation date. However, this meant the provider could not be sure staff were responding to call bells in a timely manner while they waited for the new phone lines. We raised this as an issue to the management

team who said they would implement a random check audit for the interim period.

We recommend the provider seek advice and guidance from a reputable source regarding effective quality audit systems.

The local authority gave positive feedback about the service. They told us the borough had facilitated training in the 'Red Bag' initiative. This scheme involved close working with the hospital admission team to ensure dignity for people going into hospital and the red bag would hold personal belongings and documentation the hospital required. Springfield Care Centre volunteered to be part of the scheme and had sent two staff members for the training.

The manger told us they planned to work in partnership with universities for students to come into the home for work experience. They also planned to network with other managers at the local care providers forum in order to share examples of good practice. This showed the provider was willing to work with other agencies in order to improve the service.