Springfield Home Care Services Limited

Springfield Healthcare (Leeds & Wakefield)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection carried out on 18, 19 and 21 December 2017. At the last inspection in September 2016 we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Good governance. At this inspection we found ongoing concerns with governance arrangements.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

There was a registered manager in post. 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.

Medicines were not always managed safely. Records of people's medicines were not always accurate; therefore we could not be assured people received their medicines as prescribed. We saw that in other areas of medicines management and administration there was good practice.

We have made a recommendation about the management of medicines at the service.

The service provided good training and support for staff, which included mandatory training, induction, supervisions and appraisals. People told us they felt confident staff were trained to a good standard. However, we found that in the area of stoma and catheter care, there was a training gap which had not been identified.

There were systems and processes in place to monitor the quality of the service and identify and act upon issues found, however audits did not always take place as scheduled. Audits did not pick up the issues we identified in medicines recording and training needs.

People told us they felt safe in the care of staff, and there were systems and processes in place to protect vulnerable people from harm. Risks to people were appropriately assessed and managed.

There were enough staff to deliver care safely, and the service was actively recruiting to make sure staffing levels were increased to help cope with sickness, leave and absence.

People were supported to eat and drink enough to maintain a healthy diet, and people's preferences were taken into account. People also told us they felt well supported to access healthcare services by staff who knew when to make an appropriate referral.

People told us they were cared for by kind and compassionate staff. People told us their independence and

dignity were protected and promoted by knowledgeable and considerate staff.

The service was working under the principles of the accessible information standard by including information about the principles of the standard and what support people needed to accessible information in an equitable way.

Care plans were person centred, with clear guidance for staff on how to care for people in the way they wanted. Care plans included information about people's life history, cultural and religious preferences and interests.

People told us they knew how to make a complaint, and complaints were responded to appropriately.

Staff supported people to maintain active social lives and participate in meaningful activities, and consulted with people of similar age groups to ensure activities were appropriate for them.

The service sought feedback from people who used the service and acted upon their responses accordingly, analysing data for trends and themes. Staff told us they felt well supported, and that there were plenty of meetings and communications from the service, which kept them up to date with important information and developments.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Good governance. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines records were not always accurate. We found medicines administration records with missing signatures and wrong dates which had not been identified.

There were enough staff to care for people safely and staff were recruited in a safe way.

Risks to people were assessed appropriately and people told us they felt safe in the care of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received sufficient training and support to carry out their roles. However, we found not all staff had received training in catheter and stoma care.

People were supported to eat and drink enough to maintain a healthy diet, and people were supported to access healthcare services appropriately.

Staff and management had an understanding of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and compassionate staff.

People's dignity and privacy was maintained by staff who were able to describe in a sensitive way how they approached this.

People's independence was promoted and supported by staff. The service was working towards achieving the accessible information standard.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a person-centred way, which gave good detail on how to care for people in the way they wanted.

People were supported to access the community and partake in activities which took into account their interests and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although there were governance systems in place, they did not identify the issues we found with records and training.

Staff felt the leadership of the service was open and accessible, and staff felt communication from meetings and memos was good.

People's feedback was sought through surveys, and negative trends and themes were identified and acted upon by the service.

Springfield Healthcare (Leeds & Wakefield)

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 checked 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 18 December 2017 and 21 December 2017 and was unannounced. The inspection was carried out by two adult social care inspectors, one specialist advisor with experience in governance, and three experts-by-experience who made telephone calls to people using the service to gather feedback. 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 gave the service 5 days' notice of the inspection site visits because the service is very large and we needed to arrange staff focus groups and ensure we could arrange a home visit.

Inspection site visit activity started on 18 December 2017 and ended on 21 December 2017. It included visiting the provider's office to see the registered manager and office staff and to review care records and policies and procedures. We conducted two home visits to a person using the service

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the service. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us. We contacted the local authority for feedback on the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the time of the inspection, there were approximately 400 people receiving personal care, which is a regulated activity. During our inspection, we spoke with 18 people who used the service and eight relatives of people who used the service. We also spoke with ten staff, including nine care staff and the operational manager. We reviewed records relating to people's care, such as medical administration records, care plans and risk assessments, staff files and a range of records related to the management and operation of the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed the systems around the administration of medicines at the service and found that there were failings in the recording of medicines administration, which could put people at risk of overdoses or missed doses. Several medicines administration records (MARs) had missing signatures with no explanation given as to whether or not the dose was given or whether there was another reason for the absence of a missing signature. We found several charts with incorrect dates, for example one chart began on 11 December 2017 and ended 7 February 2017. Another recorded the start date as 28 October 2017 and ended 24 October 2017. On another MAR we found an instance where information on the chart was erased with correction fluid, and there was no explanation available.

We did not see evidence that there was poor practice in other aspects of medicines administration. People we spoke with said that they received their medicines as prescribed. One person said, "They administer my medicines from the blister pack and yes I get them when I should do." Another person said, "Yes, they apply creams to my back and legs every morning and evening." Staff had received training in medicines administration, and staff told us they felt well supported in this area.

Care plans detailed and described peoples medicines, level of the administration required by the staff and provided clear direction about what support people required to take their medicines. There was information on allergies and person centred information about how people wanted to take their medicines. Body maps were used when topical creams were required which provided staff with information on where to apply the medicines and in most care plans we found PRN protocols in place in line with national guidelines.

In light of our findings we recommend the provider reviews their systems and processes for recording medicines administration to ensure staff accurately reflect medicines that they have given or supported people to take.

Everyone we spoke with told us they felt safe being cared for by staff. One relative we spoke we said, "No issues here, I find them pleasant and friendly. My relative looks forward to them coming and is comfortable with them." Another person said, "I trust them, nothing bad has ever happened. They are caring people."

There were systems and processes in place to protect people from abuse. Staff had received training in safeguarding vulnerable adults and were able to describe how they would identify and prevent abuse. For example, one staff member said, "There was one lady I went to and she was covered in bruises and couldn't provide an explanation, so I raised this with the manager and it was investigated and assessed by clinicians. It turned out they had had a nasty fall." All safeguarding incidents were reported to CQC and the local authority appropriately for monitoring and further investigation.

Staff were recruited safely. We reviewed five staff files and found that appropriate background checks were carried out, including professional references, a record of valid ID presented, and a Disclosure and Barring Service (DBS) check carried out on each member of staff. The DBS is a national agency which uses the police national database to help employers make safer recruitment choices.

There were enough staff to deliver care safely. The service operated across a wide area covering two local authorities, Wakefield and Leeds. In Wakefield, the operations manager told us there were enough staff, however in Leeds they were slightly under their targeted staffing establishment. We saw evidence that the provider was advertising vacant posts, and the provider had recently hired eight new staff, in response to 11 up and coming planned vacancies due to maternity leave and retirees. The operations manager said that their key issues were timeliness and lateness. At the last survey sent to people using the service in June 2017, of 208 people who responded 154 said staff were 'always' on time, 53 said 'sometimes' and one person said 'never'. One respondent commented, 'Sometimes they can be late but otherwise I am happy'.

We saw evidence that there was a disciplinary procedure in place and that where there were repeated instances of lateness or unexplained absence appropriate action was taken. Staff gave mixed feedback on staffing levels, however staff did not say they felt staffing was unsafe. For example, one member of staff said, "It's a catch 22, sometimes we are overstaffed and don't get the hours we want, but a sickness at short notice can impact our workload. It is a balance. Sickness has been high but is going down recently." Another staff member told us that sickness had been high in their team recently, but they made sure all care was delivered safely. They said, "We try to fit it in for the clients."

We saw there were eight missed calls in 2017, and that action had been taken to address this. This included visiting the people missed and apologising, refresher training for staff involved and a requirement for staff to submit their times to their supervisor daily.

Risks to people and staff were assessed properly with actions to be taken by staff to mitigate these risks as much as possible. Risk assessments included an environmental risk assessment for people's homes, which gave information on utilities providers and the location of their supply, as well as fire safety information. Where people had specialised equipment such as hoists and wheelchairs, a full risk assessment had been drafted including when they were last inspected and by whom. Each person had an individualised 'client risk assessment' which included a falls risk assessment, choking risk assessment, any history of self-harm or drug abuse and any security risks to the person such as a history of financial abuse.

Staff received training in how to prevent infections and had good access to a stock of personal protective equipment (PPE). When we conducted a home visit we saw that staff were using PPE to prevent the spread of infection and they disposed of them appropriately and safely when they were finished.

Requires Improvement

Is the service effective?

Our findings

In general, training needs were met, and staff told us they received adequate training to perform their roles. The provider used a training matrix to monitor and observe compliance with training the provider considered to be mandatory. This included courses such as moving and handling, basic first aid and safeguarding vulnerable adults.

However, we found there was a gap in training related to stoma, catheter and continence care to support the needs of people using the service, which had not been identified. This module of training was brought in as part of the induction process, and once staff completed the course they were not required to re-take it again. However, there were a number of staff who had taken the previous induction which did not include this training, and they had not been provided with any training in this area since joining the service. This meant there were 18 staff who had been potentially practising stoma and catheter care who had not received training to do so.

When we raised this with the operations manager they booked all staff on the next available course in January 2018. Where people had stoma or catheter care needs, national guidelines were available in their care plans with clear instructions for staff to follow. We saw no impact on people's care, health or wellbeing of this shortfall in this area of training.

We recommend the provider reviews all staff training to ensure any training gaps are identified and addressed.

Most people we spoke with said that staff acted professionally and were competent in their roles. One person said, "I think they are very professional, they seem to know what they are doing."

The induction process included five days of 'mandatory training', and new staff 'shadowing' established staff on shifts. Performance was reviewed weekly by senior staff until week 13 where a final review was held where the suitability of the staff member to continue work was assessed. Staff who had facilitated the shadowing of new staff told us they were also asked their opinion on the effectiveness of new staff. They said their input had an impact on new staffs' review and whether they were suitable to continue or required more support. One member of staff said, "I did a review for a new member of staff and said I felt they needed more shadowing in my feedback and the manager made sure they got it."

Staff were supported with regular spot checks, observations and appraisals. Spot checks included observing how staff used equipment, practiced effective infection control and involved people by asking them if they were happy with the staff member's performance. Staff we spoke with told us they felt these were a useful conversation where they could discuss issues with their caseload and any further development they were interested in. Staff told us they were regularly offered support to develop their careers if they wanted, and were supported to achieve further qualifications in health and social care.

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.

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 authorisation procedure for this in community settings is via application to the Court of Protection.

We checked whether the service was working within the principles of the MCA. Staff were provided with training on mental capacity and told us they understood the importance of consent, and that they were confident care plans would provide appropriate guidance and information. Care records we reviewed included relevant assessments conducted by the local authority with guidance based on the principles of the MCA and evidence of best interests decisions made in partnership with people and their families.

People were supported to maintain a healthy nutritional balanced diet by staff who made food and prepared drinks the way people wanted. One person said, "Yes I have my breakfast, lunch and tea and it's how I like it." Another person said, "I get breakfast and a cup of tea every day and it's always how I like it done."

Staff we spoke with were knowledgeable about risks to people with eating and drinking and told us how they helped people with specific needs. For example one staff member said, "I have one lady who needs a thickener in her drink to prevent choking, and we use nutritional and liquid charts to record what she has had." Care records we reviewed contained detailed information about what food people had eaten, and care records included up to date flood and fluid charts which were based on national guidelines.

Staff worked to ensure people's health and wellbeing was maintained by knowing people's medical conditions and raising any observations they had about changes to people's health. One staff member said, "We are constantly in contact with senior staff, we get involved in care plan reviews, for example if there is someone with deteriorating mobility we will refer them to the right people." One person told us, "They always check me for sores and can see if anything needs addressing with the doctor. They are on the ball."

Good

Is the service caring?

Our findings

People we spoke with told us staff were kind and compassionate. Comments included, "They are above caring – so good, I get to know them as friends" and "They are always caring to me, they are all lovely." One relative we spoke with said, "They seem friendly and pleasant my son really enjoys his outings with them."

People's dignity and privacy was protected and promoted by staff. One person told us, "They always knock before coming into the house." When we asked one person if staff made themselves known and knocked before entering people's homes they said, "Yes, they do otherwise they wouldn't get into my house!" Staff were able to describe how they would protect people's privacy and dignity, for example, one member of staff said, "If we are washing someone's top half, we keep the bottom half covered and vice versa. We are always talking to them as we help, asking them what they need us to do." At the last annual survey sent to people using the service in June 2017, of the 208 responses 200 people said staff always respect their privacy and dignity, and nobody said staff never respected their privacy and dignity.

The service promoted people's independence in a positive way. Staff told us they would encourage people to do what they could for themselves, in a safe way. One staff member said, "For example with washing, we tell them you do what you can and we will do the things you can't. On the other hand, if people were at risk say for falls, we would never encourage them to do something they couldn't, but we would still ask consent." Care plans were written in a way that linked people's care to their independence as an objective as much as the person wanted. In one care plan we saw it was noted, 'I am a very independent person and like to do most things for myself'.

The service demonstrated that it was achieving the accessible information standard. In each person's care records there was a questionnaire which included the principles of the accessible information standard and what help people needed. For example, in one person's care plan it was written that they were registered blind as they were partially sighted, but did not use braille or any extra support from staff at the time.

The service recorded compliments from people who used the service to highlight with staff positive feedback from people. We saw that comments praised staff attitude. One compliment read, 'The quality of care was excellent and [Name] always looked forward to carers coming.'
We visited two people's homes, and when we asked them if staff provided explanations when delivering care, they told us that they always let them know what they were going to do before they carried out any tasks. This helps promote people's independence and dignity.

The service provided information on how to access an advocate. An advocate is a representative of a person to help them make important decisions in their lives, for example what social activities they wanted to do and to attend meetings relevant to their care.

Good

Is the service responsive?

Our findings

Care plans were person centred and reflected people's needs and preferences in an accessible way. Descriptions of the care people needed such as help with mobility or nutrition were clearly linked to aims and objectives. For example, to promote independence or uphold people's dignity. Care plans also included information on people's religious and cultural needs, as well as a life history which gave some information on their friends and family networks and interests.

There was clear guidance for staff on how to care for people in the way they wanted. For example, in one moving and handling care plan staff were instructed to help someone get out of bed in a way the person felt comfortable with: 'One carer to stand behind me and another to get my stand aid. I will then turn on the edge of the bed with the carer to support my back. Push the stand aid under me. I will pull myself up.'

People we spoke with said they were involved in creating their care plans, and that they were reviewed regularly in partnership with them. One person told us, "Yes, me and my husband asked for a change to the tea time visit." One staff member said, "The supervisors do care plan reviews, we get involved if there is a change that needs our input. We reviewed 20 care plans and saw they were regularly reviewed.

There was a complaints process, which included responsibility and periods for investigating and responding to complaints. People told us they were confident they knew how to make a complaint. Complaints were appropriately investigated and responses were written in a sympathetic tone. We spoke to one person who had made a formal complaint about the suitability of their care staff. They told us they were happy with the way Springfield Home Care Services Limited dealt with their complaint. Other people we spoke with said they knew how to raise a concern. One person said, "I would ring the office if I had a concern."

People were appropriately assessed before they began using the service. This included collecting information about a person's medical history, support network, diet, mental health needs and expectations they had of the service. People told us they were seen by the care manager and social services where necessary and asked questions to determine their needs. One person said, "Yes an occupational therapist and the manager came out to assess my husband's needs."

The service also supported people to access the community and achieve their social activity aims in a positive way. People told us they were supported with trips to the shops, pubs and partaking in their favourite activities. One person told us, "When we go to the club to play snooker [the carer] doesn't introduce herself as my support worker but says she's a friend." The service also organised a regular social group of clients of similar age to take them on trips they wanted to go on. One relative said, "They have put together a small group of adults where they choose their own activities. Two support workers come and take them all out together. The last two were they went to a pantomime and a local pub for a meal out. My son is very sociable and really looks forward to these and really enjoys it."

The service was not providing end of life care at the time of the inspection, however the registered manager assured us that they would take the lead from healthcare professionals and that any specialist training

needs could be met.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that there was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed the quality monitoring systems in place at the service and found that although some improvements were made, the service was still in breach of this regulation.

Audits were carried out on various areas of quality such as medicines, training and care notes. We reviewed medicines audits which had not identified recording issues we found . For example, one MAR had an 'as required' medicine documented which had been administered, however no times were documented on the MAR as to when this was administered which is best practice. According to the provider's policy and audit standards this should have been identified as an issue, however, this was not noted by the auditor and no actions were taken. We also found another MAR where a medicine that was directed to be given only on Monday and Thursday morning had been signed for as given every day by a staff member for that week, and this was not picked up by the audit and no actions were taken.

Some records we requested were missing and unaccounted for. Other MARs were missing from files and when we requested these they were not at the provider's office. For example, one person's MARs were last audited in June 2017 and no other MAR charts were available at the office. We saw another person's MAR record that had not been audited since August 2017. We found one person's MAR from November to December 2017 but MARs from April to September 2017 were not at the office and therefore we could not be sure if these had been audited. The service's policy did not specify when these should be audited, stating simply that they should be audited 'regularly'

The manager told us they had recently introduced a tracker system to monitor the auditing of MARs to ensure there is consistency throughout. The manager also told us that they were aware of some of the recording issues and that this had been discussed in their recent governance meeting in November 2017.

We found when audits did operate as they should have, actions to be taken were recorded clearly. For example, 'memo sent to carers' to remind staff to record on the MARs and 1-1 meetings with staff. The manager told us all staff had recently completed refresher training on medicines to prevent future recording issues. Following our inspection, the provider told us that staff members responsible for completing audits required further support and development in their roles.

Although staff received a mixture of spot checks, supervisions and appraisals, these were not always conducted in line with the provider's policy. For example, we saw one staff member had not received an appraisal since November 2015 and four staff had not received an annual appraisal despite having been there for over a year. Additionally, we found one staff member employed since 2014 had one supervision recorded on their file. The policy states that annual appraisals should be completed and four supervisions carried out within 12 months. In one of the files we reviewed, we found that there were supervision records that concerned another member of staff and were in the wrong file.

Furthermore, although the service monitored compliance with staff training, we found there were 18 staff who had not completed catheter and stoma care training which was linked to the needs of people using the service.

We concluded therefore this was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Good governance.

We did note that although supervisions were not always completed regularly we found that other quality monitoring measures such as spot checks and staff observations were carried out regularly including discussions with staff about their performance, and staff told us they felt well supported. We discussed this with the manager and they amended their policy during the inspection to include spot checks and staff observations as being an acceptable alternative to supervisions.

Staff we spoke to were positive about the leadership and culture at the service. One member of staff said, "When you come into the office senior staff talk to us, we have a chat, they are friendly and approachable." Another member of staff said, "The office staff let you know they are only a phone call away."

The service sent an annual survey to gather feedback from people. We reviewed the findings and actions from the latest survey in June 2017. The survey was split between the Leeds and Wakefield areas. Out of the 396 surveys sent, there were 208 responses. The survey showed an overall satisfaction with the service in a number of areas, for example of the 208 responses to the question 'Are carers polite and friendly?' 195 people said 'Yes', 13 said 'Sometimes' and nobody said 'Never'. The survey was analysed for trends and themes, and actions were taken as a response, for example, in one area three people said they did not know how to make a complaint. In response, staff were instructed to remind people which number to call and how to make a complaint on their next visit. Some people we spoke with said they were regularly contacted. One person said, "I have had quite a few questionnaires over the years". The majority of people with spoke with told us they would recommend Springfield Home Care Services Limited.

The service gathered feedback from staff in a variety of ways. For example, the service conducted an annual survey. The latest annual survey was conducted in June 2017 and there were 52 responses. There were positive responses in areas such as teamwork, opportunities and respect for employees. Neutral or negative responses included work life balance, stress and communication. The survey was analysed and there were actions noted as a response to the survey. This included a review of other care companies to assess pay levels, support for staff suffering stress and a review of communications.

There were regular team meetings every three months for each team. Staff were also sent memos via email to inform them of any news or changes. For example, any new clients, staff changes, dates for future training courses and areas for improvement in response to feedback, or as a result of audits. One member of staff said, "We are always having meetings and getting memos, we feel in the loop."

Staff we spoke with told us they enjoyed their job because of the difference it made to people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Medicines audits were not always effective and quality monitoring systems did not identify gaps in required training. Records were not always well maintained.