Madeprice Limited

Springkell House Care Home

Inspection report

Springkell House
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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

Springkell House Care Home is a residential care home for up to 35 older people living with dementia and conditions that affect their mobility. Care is provided across two floors in one adapted building. At the time of our visit there were 31 people at the home.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Why the service is rated Good.

Care was delivered safely with risks to people routinely assessed and planned for. Staff responded appropriately to incidents and understood their roles in safeguarding adults' procedures. Medicines were managed and administered safely by trained staff. The home environment was clean with regular checks carried out to ensure its safety.

People were prepared food that they liked and their dietary needs were met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The home environment was adapted to people's needs and we observed people could move around the environment safely. People's needs were assessed before they came to live at the home and staff supported people to access healthcare professionals. Staff had the right training and support for their roles.

Staff were kind and we observed interactions which demonstrated they had a caring nature. Staff knew people well and routinely involved people in their care. Care was provided in a way that encouraged people to maintain their independence. Staff were respectful of people's privacy when they provided care in a dignified manner.

People had access to a range of activities and staff gathered information about people's backgrounds and preferences to enable them to provide personalised care. Care plans were regularly reviewed and changes in needs were responded to. Staff planned end of life care in a sensitive and personalised manner. People and relatives knew how to raise a complaint and were confident their concerns would be addressed by staff or management.

People told us they liked the registered manager and we saw that they had regular opportunities to make suggestions about the home. Staff felt supported by management and systems were in place to enable good communication between staff. There were a variety of checks and audits at the home to monitor the

quality of care delivery. People benefitted from the provider's links with the local community.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Springkell House Care Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection that took place on 18 September 2018 and was unannounced.

The inspection was carried out by one inspector, a specialist advisor nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

Before the inspection the provider sent us a Provider Information Return (PIR). This is information we 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. We took this into account when we inspected the service and made the judgements in this report.

As part of the inspection we spoke with 17 people and one relative. We spoke with the registered manager, the administrator, an activities co-ordinator and four care staff. We reviewed care plans for four people, including risk assessments, daily notes, mental capacity assessments and applications to deprive people of their liberty. We also checked a variety of audits, meeting minutes and records relating to the governance of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe at the home. One person said, "I feel very safe." Another person said, "It feels fairly safe as I am at the top of the building." Another person told us, "I don't think you could find any better. I like this place and I like their [staff] attitude."

People continued to be kept safe by plans to mitigate risks. Care plans contained risk assessments and where staff identified risks, clear plans were implemented to keep people safe. For example, one person was assessed as being at high risk of falls. To reduce the risk of a fall occurring, the person was supported by two staff who used equipment to support them to move.

Where incidents had occurred, staff took action to prevent them from happening again. Staff recorded all incidents and the actions taken and these were monitored by the registered manager. Where one person had multiple falls in a month, we saw evidence of new measures being introduced after each fall. These included increased checks, equipment and lowering the person's bed. Records showed falls had reduced for this person following the introduction of these measures.

People's medicines continued to be managed safely. Best practice was followed to ensure medicines were stored securely and in line with the manufacturers guidance. Records regarding people's medicines were up to date and we saw healthcare professionals were involved when required. Where one person received their medicines covertly, staff had obtained authorisation from the GP and pharmacist and followed the correct legal process relating to consent. People's medicines were regularly reviewed and the provider carried out checks and audits of medicines.

Staff understood their roles in safeguarding people from abuse. Staff training included courses on safeguarding adults and information about how to raise concerns was on display within the home. Staff were able to tell us how they might identify abuse when we spoke with them and they knew how to escalate any concerns that they had.

People lived in a clean and safe home environment. The home was clean with no malodours and we observed domestic staff cleaning communal areas and people's rooms. Staff followed best practice in relation to infection control and we observed them washing their hands before and after care. The provider regularly audited infection control and ensured checks were carried out on the safety of the environment and equipment and processes to reduce the risk of fire were regularly checked.

There were enough staff present to meet people's needs. The provider calculated staffing levels based on the needs of people and records showed these levels were sustained. People and staff told us that staff were able to meet people's needs and responded promptly to calls to help. There was low use of temporary agency staff and where new staff had been recruited, all necessary checks had been carried out to ensure staff were suitable for their roles.

Good

Is the service effective?

Our findings

People told us that they liked the food that was prepared for them. One person said, "It's lovely." Another person said, "It's always well prepared." Another person told us, "Greedy piggy that I am, I have put on pounds and inches since I've been here."

There was a menu each day with a choice and the kitchen staff could prepare alternatives for people who requested them. People were regularly asked for their preferences and any feedback on the food they received. Where people had specific dietary needs, these were documented. For example, one person required soft foods due to difficulty swallowing and this was in their care plan. The provider also introduced fortified milkshakes twice a day which were popular with people. Where one person did not like milk, a fortified vitamin drink with juice was prepared for them.

The provider also took part in a 'Hydrate' project with the clinical commissioning group (CCG). This included initiatives to encourage people to drink more such as 'juice of the day' which provided a drink people had helped to choose that they could help themselves to in the lounge. The registered manager regularly audited people's weights and important information about people's food and fluid intake was recorded in care plans.

People received a thorough assessment before they came to live at the home. Assessments covered all aspects of people's needs, any risks and their choices. Where one person had used their assessment to inform staff they liked to get up early, we saw that this preference was added to their care plan.

The home environment was suitable for people's needs. The building had been adapted to include a lift to ensure people who used walking aids could safely access the whole home. Doorways and corridors were wide enough for people to move freely between rooms and we observed them doing so throughout the day. There was signage around the home to help people living with dementia to orientate themselves within the environment.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed that staff had carried out mental capacity assessments to identify if people could make specific decisions. Where one person was unable to make a decision to live at the home, a best interest decision had been recorded to state that it would be in their best interests to remain at the home. The provider had considered the person's wishes, involved relatives, staff and the person's social worker. As staying at the home meant the person faced restrictions, an application had been submitted and authorised by the local authority DoLS team.

Staff had received appropriate training and support for their roles. Staff had received an induction and the

provider kept a record of training courses to ensure it was regularly refreshed. Staff completed the Care Certificate as well as further qualifications in adult social care. The Care Certificate is an agreed set of training standards for staff working in a care setting. The registered manager also carried out regular good practice discussions with staff at meetings as well as ensuring staff had training in areas such as dementia. Staff had been to a 'dementia bus' which was an immersive experience that replicated some of the symptoms of dementia on staff. We received positive feedback on this and staff told us it had an impact on how they supported people who were living with dementia. Staff also received one to one supervision meetings and appraisals.

Good

Is the service caring?

Our findings

People told us that the staff who supported them were caring. One person said, "The staff are very polite, very friendly." Another person said, "I'm very well looked after." Another person told us, "There's a happy atmosphere between staff and residents."

During the inspection we observed staff interacting with people warmly, in a way that demonstrated kindness and respect. In the morning, staff noted one person appeared to be slipping in their chair. Staff went over to the person and asked them if they were comfortable. Staff got down to the person's eye level and placed a hand on them. The person told staff they were comfortable and staff supported the person to adjust slightly before allowing them to sit as they wished.

Staff involved people in their care. Care plans documented information about people's preferences and people were regularly asked about these. Where people had expressed preferences or choices, these had been documented. Regular meetings took place where people were asked about their care and their home. During the inspection, we observed staff offering people choices. For example, after lunch one person was not sure whether they wished to take part in an activity. Staff allowed the person time to make a choice and they chose to go to their room for a rest. Staff supported the person to do this. Another person liked to have their meals in their rooms and this was documented and records showed they regularly received their meals in line with this preference.

People were supported in a way that encouraged them to be independent. Care plans recorded what people could do for themselves and the support that they required to be independent. For example, one person was living with dementia and was able to dress themselves. However, sometimes they forgot to have their clothes washed so the care plan contained guidance for staff on how to deal with this sensitively whilst allowing the person to maintain autonomy over their clothing choices.

Staff were respectful of people's privacy and dignity. Staff provided care in a way that ensured people's privacy was maintained. Where personal care took place, it was done discreetly behind closed doors. Staff knocked on people's doors and waited for permission before entering. The provider carried out regular audits of dignity which included observations as well as checks of records and staff practice.

Good

Is the service responsive?

Our findings

People told us that they liked the activities on offer. One person said, "They help me to do what I can." Another person said, "The activities are as good as they can be." Another person told us they did not like group activities and they were supported on a one to one basis which was preferable to them.

People were able to access a variety of activities at the home. The provider employed staff who carried out activities with people. Rotas were planned so staff were able to conduct activities throughout the week. Activities covered a range of interests such as music, arts and physical exercise. We observed activities staff engaging people in games in the morning and this created a pleasant atmosphere in the lounge. There was art on display within the home that had been created by people and some had involved pupils from a local school. People were regularly asked for suggestions regarding activities at regular meetings.

Care was planned and delivered in a personalised way. Care plans contained important information for staff about the support people needed and any preferences that they had. Care plans contained a lot of detail but also provided a summary which helped staff to identify what was important to people. One person had specialist needs around continence and their care plan provided detailed guidance for staff on how to support them. Another person was living with dementia and there was guidance for staff on how to reassure them if they became lost or confused. We also saw evidence of people's wishes and preferences being fulfilled, such as one person who liked to spend time alone in their room. This was documented in their care plan and staff were aware of this person's wish to remain in their room and receive their meals there. Care plans contained evidence of regular reviews and we saw evidence of reviews taking place when things changed. For example, staff had noticed changes to one person's mobility so reviewed and updated their care plan to reflect the additional support they required.

End of life care was planned sensitively and catered to people's needs. Care plans contained information about people's advanced wishes and these had input from relatives, professionals and staff to ensure a holistic approach., For example, one person did not wish to be admitted to hospital in the event of their health deteriorating. This wish was documented along with personalised information such has specific religious needs the person had that would require action from staff if they reached the end of their life.

People were informed of how to complain. One person said, "If I wanted to complain I would speak to one of the carers." The provider had a complaints policy which was displayed within the home and people told us they felt able to raise any issues that they had. At the time of our visit, there had been no recent complaints but people were regularly given opportunities to raise any issues through meetings and surveys.

Good

Is the service well-led?

Our findings

People told us they had regular contact with the registered manager and got on well with her. One person said, "[Registered manager] is a very good person." Another person said, "The home is well run." Another person told us, "[Registered manager] is very helpful." A relative said, "[Registered manager] is available if needed, she is very approachable." We observed the registered manager interacting with people throughout the day and these were pleasant exchanges that demonstrated kindness and compassion.

There was a registered manager in post who had managed the home for a long time. 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.

Staff told us that they felt supported by the registered manager and were encouraged to make suggestions. One staff member said, "If we have got a new idea we can go and discuss it with our manager." Staff told us they had given ideas for activities and events that had been taken forward. There were regular staff meetings and minutes showed that these were used to pass on important messages, share ideas and discuss best practice. The registered manager told us they planned short good practice sessions based on any current needs of people at the home or requests from staff to further their knowledge. A daily handover meeting took place where staff discussed people's needs and passed on important information between shifts. We observed a handover meeting and noted it was thorough and provided an opportunity for staff to receive an update on every person that they were supporting.

People were involved in the running of the home. We saw records of regular residents and relatives' meetings that provided opportunities for them to make suggestions about the home and their care. Minutes were kept of meetings and these showed that they took place regularly and were well attended. Minutes of a recent meeting showed discussions were held about changes to mealtimes and activities at the home. A relative said, "There have been to two or three meetings, I've found them useful, staff are very open to questions."

There were a variety of checks and audits in place to monitor the quality of the care that people received. The registered manager carried out regular audits to check the quality of care in areas such as documentation, the environment and cleanliness. Records showed these were up to date and where improvements were identified, these were added to an action plan and signed off when completed. For example, a recent documentation audit identified some missing information regarding DoLS for one person. This was added to an action plan and signed off as completed. We saw this had been addressed by the time of our visit.

People benefited from the provider's links with the local community. We saw evidence of activities being planned with local community groups and charities. For example, one person regularly attended a knitting group where they knitted items to be donated to charity. Staff had supported the person to find this group

due to them having an interest in knitting. People's records contained evidence of regular communication with stakeholders such as healthcare professionals and the local authority.