Annesley (Oldercare) Limited

Springfield Care Home

Inspection report

Lawton Drive
Bulwell
Nottingham
Nottinghamshire
NG6 8BL
Tel: 0115 927 9111
Website: www.springfield-carehome.com

Date of inspection visit: 12 August 2015
Date of publication: 01/10/2015

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

Overall summary

This inspection took place on 12 August 2015 and was unannounced.

Accommodation for up to 40 people is provided in the home over two floors. There were 25 people using the service on the day of our inspection. The service is designed to meet the needs of older people.

There is a registered manager and she was available during the inspection. 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.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to

Summary of findings

accidents and incidents. The premises were managed to keep people safe. Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Medicines were safely managed.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate and adaptations had been made to the design of the home to support people living with dementia.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care.

People's needs were promptly responded to. Care records provided sufficient information for staff to provide personalised care. Activities were available in the home. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management and that the registered manager would take action. There were systems in place to monitor and improve the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were managed to keep people safe.

Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Medicines were safely managed.

Good

Is the service effective?
The service was effective.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate and adaptations had been made to the design of the home to support people living with dementia.

Good

Is the service caring?
The service was caring.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care.

Good

Is the service responsive?
The service was responsive.

People's needs were promptly responded to. Care records provided sufficient information for staff to provide personalised care. Activities were available in the home. A complaints process was in place and staff knew how to respond to complaints.

Good

Is the service well-led?
The service was well-led.

People and their relatives were involved or had opportunity to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management and that the registered manager would take action. There were systems in place to monitor and improve the quality of the service provided.

Good

Springfield 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 inspection took place on 12 August 2015 and was unannounced.

The inspection team consisted of two inspectors 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 service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottingham to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with four people who used the service, five visitors, one healthcare professional, four care staff, the registered manager and the two directors of the provider company. We looked at the relevant parts of the care records of four people, the recruitment records of two staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and they had no concerns about the staff caring for them. They told us they would speak with the manager or their GP if they had any concerns.

Staff told us they had received training in safeguarding vulnerable adults and were able to describe the signs and symptoms of abuse. They said they had no concerns about the behaviour or attitude of other staff and said if they did they would speak to the staff involved and report it to the manager. They were confident the manager would deal with it but would escalate to the provider or use the whistleblowing policy if necessary. A staff member said, "They [people using the service] are number one." A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was displayed in the main reception of the home to give guidance to people and their relatives if they had concerns about their safety. Accurate records of any potential safeguarding issues were maintained by the home.

We saw staff assisting people to move safely and encouraging them to use their walking aids as required. We found the service was using a risk assessment pack provided by the local Clinical Commissioning Group (CCG) which included a full range of risk assessments including nutrition, falls and pressure ulcers. The risk assessments had been completed and reviewed monthly.

We saw documentation relating to accidents and incidents in people's care records and the action taken as a result. For example a person had suffered a skin tear when they were moved and there was a record of how it had occurred, a referral to the community nurse for advice on the care of the wound and referral to the occupational therapy service for advice on how to safely assist the person to move. However, we saw that one incident had taken place and a form had not been completed. This related to a person who bruised their hand accidently. The registered manager agreed that the form should have been completed and immediately asked the staff member to complete it.

We saw there were plans in place for emergency situations such as an outbreak of fire. A business continuity plan was in place in the event of emergency. We saw that personal emergency evacuation plans (PEEP) were in place for people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. Appropriate checks of the equipment and premises were taking place and action was taken promptly when issues were identified.

The premises were generally well maintained and safe, however, some radiator covers were not securely fixed to the wall and the hot water temperatures in one sink and one bath were too hot which could put people at risk. The manager and provider agreed to address these concerns immediately.

People told us there were sufficient staff to meet their needs. Most relatives thought there were enough staff on duty, although one relative said, "An extra pair of hands would be very good." Staff told us they felt there were normally enough staff on duty to provide the care people required. They said if there was unplanned absence staff were flexible and the shifts were covered without the need to use agency staff.

Systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The registered manager told us that staffing levels were based on dependency levels. They told us that any changes in dependency were considered to decide whether staffing levels needed to be increased. We looked at records which confirmed that the provider's identified staffing levels were being met. We observed that people received care promptly when requesting assistance in the lounge areas and in bedrooms.

Safe recruitment and selection processes were followed. We looked at two recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

Medicines were safely managed. People told us they received medicines when they needed them. Relatives also confirmed this. We observed staff administering medicines and saw they talked with the person about their medicines and stayed with them until they had taken them. They ensured the person's preferences in relation to taking their medicines were followed.

Systems were in place for the ordering and supply of people's medicines and we saw appropriate checks were in place to ensure medicines were available when they were needed. We found medicines were stored securely in a locked trolley and locked cupboards and the required

Good

Is the service safe?

temperature checks of the storage areas were recorded. We looked at the arrangements for the safe storage and administration of controlled medicines and carried out stock checks of two controlled medicines. These were in line with requirements. The home carried out weekly medicines audits which included a check of all controlled medicines.

We looked at 15 Medicines Administration Records (MAR) and found there was a front sheet for each person with a photo of the person for ease of identification and details of allergies and their preferences in relation to taking their medicines. We found the MARs had been completed consistently but there was a gap in the administration of one medicine for a person the previous day. We carried out a stock check of the medicine and found the amount remaining suggested the medicine had been given. The member of staff who had administered the medicines the previous day was on duty and we talked with them about it. They said they had administered the medicine and were distressed they had made an error. The manager was informed and they told us they would address the issue.

We found that when handwritten entries had had to be made on the MARs, this had been checked and initialled by two staff except in the case of one medicine where there was no witness initial recorded. We found that there was no record to show where on a person's body prescription skin patches were to be placed to ensure rotation of the site of application. Protocols were not in place to provide additional information for staff on the reasons for giving medicines which were prescribed to be given only when necessary. We talked with the managers about this and they said they would put them into place.

Staff had received training in medicines administration and had annual competency checks to ensure they maintained their competency. The provider told us they used the CCG medicines policies in the home and we saw copies of these were available for staff.

Good

Is the service effective?

Our findings

People told us they felt that staff knew what they were doing. Most relatives agreed, although one relative said, "I had to tell a [staff member] how to change an oxygen cylinder." We observed that staff were confident and competently supported people. A healthcare professional told us that they had no issues regarding the quality of care at the home, however, they felt staff required more end of life care training so that they would be more confident when caring for people at the end of their life. The provider confirmed that further end of life care training had been completed by staff and would be updated again shortly.

Staff told us they received induction, regular training, supervision and appraisal. Staff felt supported. Training records showed that staff were up to date with a wide range of training which included equality and diversity training. Supervisions took place regularly and also included a wide range of learning as well as an opportunity to discuss the developmental needs of staff. Annual appraisals were also taking place and staff again had opportunity to discuss their developmental needs.

People told us that they were encouraged to make choices about their care and staff respected their decisions. Relatives told us that staff did not act against their family members' wishes. We saw that staff explained what care they were going to provide to people before they provided it. Where people expressed a preference staff respected them.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS is a code of practice to supplement the main MCA 2005 code of practice. We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The registered manager told us that applications had been made for people who might be being deprived of their liberty. We saw some people were the subject of a DoLS application and the documentation in relation to this was stored in the person's care records. Staff had attended MCA and DoLS training and had a good understanding of both.

The requirements of the Mental Capacity Act (2005) were adhered to in that when a person lacked the capacity to make some decisions for themselves, a mental capacity assessment had been completed and there were details of the involvement of others in reaching a best interest decision for the person. Assessments were decision-specific and linked to a care plan which was clearly identified as having been developed in the person's best interest.

Staff said they did not currently have anyone with behaviours that may challenge those around them living at the home and they had not undertaken any specific training. However, when they had had people with challenging behaviour previously, they identified the influence the environment and noise could have on people with dementia and said they found if they sat with people and talked with them, this often calmed them. They said there were quiet areas and they would encourage people to talk about family and look at family photos to help reduce agitation and anxiety.

We saw the care records for two people who had a decision not to attempt resuscitation order (DNACPR) in place. One of these had been fully completed indicating the person did not have the capacity to make the decision for themselves and that the person's close relatives had been consulted in the decision making process. The second DNACPR order did not indicate whether the person had capacity to make the decision themselves, but indicated the decision had been discussed with a close relative. The registered manager confirmed that they would contact the relevant GP practice immediately to arrange for the form to be reviewed.

People told us that they enjoyed the food provided to them. People and relatives told us that there was plenty to eat and drink, though two people told us they were given too much to eat. Three of the people we spoke with confirmed they were offered choices about the meals they ate, although their experiences of how this was managed varied. One person said, "We choose the day before." Another told us, "We choose in the morning [for that day]." And another said, "We are asked when we sit down for lunch." However, the fourth person we spoke with about meal choices said, "We eat what we get given. Not a problem as the cook knows what we like."

People were offered a choice of two main courses in the morning prior to the lunchtime meal. We observed the

Good

Is the service effective?

lunchtime meal for people who remained in the lounge for their meal and checked on people having their meal in their room. Clothes protectors were offered to people who required them. Meals were distributed promptly and staff told the person what they had chosen and checked they were still happy with their choice. One person said they did not want the meal and staff tried to tempt them with alternatives. The person had some difficulties in communicating and staff spent time with the person to try to find out their wishes. Staff realised the person wanted cereals which staff said they frequently asked for and after trying to persuade the person to have something more suitable as a main meal they provided them with cereals. They went back later and offered the person a hot sweet which the person agreed to and ate.

We saw some people needed full assistance to eat and drink and we observed staff sitting with them and providing them with assistance. The staff explained what was on the plate and offered encouragement. One person ate very slowly and through patience and gentle encouragement the person ate most of the portion they had been provided with.

Care plans were in place to provide information on people's care and support needs in relation to eating and drinking. There was also a record of their food preferences. Food and fluid charts were in place to record people's nutritional intake when they were nutritionally at risk although the quantity of fluid consumed had not been totalled daily which meant that there was a risk that low fluid intake would not be promptly identified.

Some people required nutritional supplements and when we talked with them about this they told us they were given them regularly by staff. We also saw that a person, who had a small appetite and who required small amounts of food frequently, was assisted to eat a yoghurt mid-morning and milky drinks were also offered. We saw people were weighed monthly and a person we reviewed who was receiving nutritional supplements had gained weight recently.

People told us they saw the GP if they needed to. There was evidence of the involvement of external professionals in the care and treatment of people using the service. We found people had pressure relieving equipment and mobility aids were in place when they were indicated as being necessary. We saw that repositioning charts were fully completed to show that people at risk of skin damage were receiving care in line with their care plans.

People told us that there were very happy with the home. One person told us that they had no difficulties moving around the home in their wheelchair. Adaptations had been made to the design of the home to support people living with dementia. Bathrooms, toilets and people's bedrooms were clearly identified. Handrails were in contrasting colour to the walls and flooring was a solid colour to support people living with dementia who could have visual difficulties. Lounge areas were comfortable and easily accessible for people.

Good

Is the service caring?

Our findings

People told us that staff were kind. A healthcare professional told us that people always looked well cared for. People clearly felt comfortable with staff and interacted with them in a relaxed manner. Staff greeted people when they walked into a room or passed them in the corridor. They checked they were alright and whether they needed anything. Staff were kind and caring in their interactions with people who used the service. Staff clearly knew people and their preferences well. However, a healthcare professional told us that staff returning from leave were not always well informed of changes in people's conditions which had happened while they were away. We looked at completed handover sheets used by staff to update their colleagues on any changes to a person's condition. The handover sheets were well completed and clear.

People told us they could make decisions about their care and most felt listened to; though one person told us that staff did not listen to them. Two relatives told us they had not seen their family member's care plan but felt that staff listened to them and respected their views. Another relative told us they had seen their family member's care plan but not recently.

Care plans were signed by the person who used the service or their relative (when the person had been identified as lacking capacity) to indicate their involvement and agreement. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences. For example one person's care plan stated staff should watch for facial expressions and signs the person liked or disliked things. Advocacy information was also available for people if they required support or advice from an independent person.

People told us they were treated with dignity and respect. People told us staff respected their privacy and two people told us that staff knocked on their bedroom door before entering. Relatives told us that staff treated their family member with respect. We saw staff knocking on people's doors before entering rooms and taking steps to preserve people's dignity and privacy when providing care. We observed that information was treated confidentially by staff.

Staff told us of the actions they took to preserve people's privacy and dignity. They identified individuals who did not like to walk to the bathroom in their dressing gown and preferred to get dressed to do this and they always respected this. The home had a number of areas where people could have privacy if they wanted it. All staff and both of the provider's directors had been identified as dignity champions and signed up to the National Dignity Council pledge. A dignity champion is a person who promotes the importance of people being treated with dignity at all times. Staff told us they had attended privacy and dignity training.

People told us they were encouraged to be as independent as possible. One person said, "The help is there when I need it." Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

People told us that their families and friends could visit whenever they wanted to. Relatives told us they were able to visit when they wanted to. We observed that there were visitors in the home throughout our inspection. People were supported to maintain and develop relationships with other people using the service and to maintain relationships with family and friends.

Good

Is the service responsive?

Our findings

We observed staff responded quickly to people's needs during our inspection.

People gave mixed feedback regarding activities. One person said, "We sometimes have a [staff member] waving our arms about." Another person told us they hadn't seen many activities taking place and three people told us that there used to be bingo, but it no longer took place. We saw staff spending time talking to people and engaging them in conversation. A variety of newspapers were offered to people and when people took these, staff returned later to ask, "Is there anything interesting in the papers today?" to initiate a conversation. However, there were no other activities taking place during the morning.

Staff told us they normally undertook activities in the afternoon and we saw people being encouraged to fold linen in the afternoon and a staff member led a sing song. However, on the day of the inspection, the weather was very warm, but we did not see much use of the outside space. We were told one staff member took people outside and involved them in gardening activities from time to time.

A staff member told us they were planning to have a "street party" in the garden with a wartime theme. They were going to dress up and had lots of plans for the day.

We saw a staff member chatting with a person who stated they wanted a shave. The staff said they would help them and we heard an exchange with another member of staff as they prepared for this, explaining the person like to have a wet shave rather than use an electric razor. A little later in the day the person made a comment to the staff complimenting them on their skills.

Each person's care records contained a care plan which provided information on their interests and activities and entertainments they enjoyed. Care plans were in place for people using the service and were written from the perspective of the person themself. They contained detailed information about the person's preferences in relation to their care. For example, the number of pillows the person liked in bed, or their preferences in regard to personal hygiene. They had been signed by the person or their close relative to indicate their involvement and agreement.

Care plans had all been reviewed monthly and were reflective of the person's current needs. We noted one person's care plan identified the person's preference for care to be provided by female carers and this was respected.

People told us they knew how to make a complaint if they needed to. Relatives told us they knew how to make a complaint and would be comfortable doing so. Staff told us if a person wanted to make a complaint they would take them to somewhere private to enable them to discuss it. They would document the person's concerns on a complaints form and notify the manager.

We saw that complaints had been responded to appropriately. Guidance on how to make a complaint was contained in the guide for people who used the service and displayed in the main reception. There was a clear procedure for staff to follow should a concern be raised.

Good

Is the service well-led?

Our findings

We had mixed feedback about whether people were involved in developing the service. One relative told us that they had attended meetings to discuss the running of the home and said, "I found it very useful and interesting." Two people told us that they had been to meetings in the past but not recently and four people were not aware of any meetings taking place. No one told us that they had completed a questionnaire asking their views on the home. However, people and relatives told us that any issues they had raised had been responded to appropriately.

Questionnaires were completed by people who used the service and their families. The response to the questionnaires was clearly displayed on the relatives and friends noticeboard in the main reception. The home produced a regular newsletter which kept people who used the service and their relatives updated regarding the running of the home and also included responses to feedback. Regular meetings for people who used the service and their relatives took place and actions had been taken to address any comments made. The home had received a lot of compliments from people who used the service and their relatives regarding the quality of care provided by staff.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues. The care home's philosophy of care was in the guide provided for people who used the service and displayed in the home. Staff were not able to describe the vision and values of the home but said the priority was the people using the service and they always put them first. Both of the staff we talked with showed a commitment to the home and the provision of care to standards they could be proud of. One said, "As long as the residents are happy and safe that is the important thing." Another told us, "I love it here. They [people using the service] are like family, if they hurt, we hurt. It is not just about care, it is seeing them as a person. They have had a life before they came here and it is understanding that. [One person] can speak four languages. Some of the stories they tell you, it makes you sit and realise."

People told us that the registered manager was approachable and listened to them. Relatives said they could talk to the registered manager. Three people told us that the registered manager was, "Very good." Staff said they felt they were listened to and they could discuss any concerns with the registered manager. They said they were also given the opportunity to contribute their views at staff meetings. One person said, "[The registered manager]) is easy to talk to. Even though she is the manager, she will come and help us. When she needs to be strict she is but she is very supportive."

A registered manager was in post and available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She felt well supported by the provider. We saw that all conditions of registration with the CQC were being met and notifications were being sent to the CQC where appropriate.

We saw that regular staff meetings took place and the registered manager had clearly set out their expectations of staff. Staff also completed questionnaires and response to their feedback was also displayed in the home. Staff were appointed as leads for the home in dementia, dignity, medication, managing continence, safeguarding adults and falls prevention so that clear guidance was available for staff in these areas.

The provider supported the manager to identify and implement good practice. The home had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks. Each commitment will focus on the minimum standards required when working in care. The commitment aims to increase public confidence in the care sector and raise workforce quality in adult social care. The provider had produced a detailed action plan to show how they would work to deliver their commitment.

The provider had a fully effective system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and also by the directors of the provider. The provider visited the home very regularly and their contact details were displayed throughout the home, so that they could easily be contacted by people who used the service, relatives and staff. Audits were carried out in the areas of infection control, care records, medication, health and safety, laundry, kitchen and domestic areas. The registered manager carried out night time visits to check that standards of care were maintained at night.

Good

Is the service well-led?

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed. Staff said if there was a complaint or incident, the manager met with the staff at handover and talked to them about it. They explored ways in which similar issues could be prevented In the future. We saw that safeguarding concerns were responded to appropriately and appropriate notifications were made to us as required. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this.