Macari Homes Limited

Springfields Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate

Overall summary

This inspection took place on 23 and 26 June 2015 and was unannounced.

The home provides accommodation and personal care to up to 20 older people. Bedrooms are on the ground floor and first floor, the first floor is accessed by a stair lift. There are communal lounges and a dining room. There were 10 people living at the home when we inspected.

There was no registered manager; there has been no registered manager since July 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspection of 2 and 3 September 2014 we found breaches of seven regulations, most of these breaches had a major impact on the people at the home.

We carried out an unannounced comprehensive inspection of this service on 11and 12 March 2015 and found that most of the breaches continued and there were new breaches of other regulations. On 22 June 2015 we received information of serious concern from the local authority. We were told that people were at serious risk of not receiving the care and support that they needed because there were not enough staff on duty at the home to look after them safely. As a result we undertook an urgent focused inspection to look into those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Springfield's Residential Home on our website at www.cqc.org.uk

Summary of findings

We found there were not enough staff available throughout the day and night to give people the care and support that they required to make sure their needs where met and they were safe. At times there were only two staff on duty for ten people and four people required the support of two staff. Some staff ignored people when they were distressed and in need of comfort.

Serious risks to people were not recognised, assessed and managed. People were at risk of choking and falling and of being neglected. These risks to people were not being managed leaving people at further risk. People did not get the care and support that they needed. Staff did not always follow the instructions of doctors and nurses to support people's health needs. When risks had been identified the provider had not followed the guidance given by professionals to keep the risks to a minimum.

Individual risk assessments were not in place to prevent or reduce the likelihood of harm. When risks had been identified, like the risk of choking or risk of developing pressure sores the provider had failed to take action to reduce the risks to make sure people were safe and receiving the care and support that they needed. When people's health had deteriorated the staff had not recognised this and had not contacted a doctor until they were prompted to do so by external professionals including the CQC inspector. People were at risk of not receiving enough drinks to remain hydrated and healthy.

Care plans were not up to date. People's needs had changed but care plans had not been updated so staff were following out of date information. Care plans had not been reviewed and evaluated so staff could not be sure that the support they gave was right for the person.

The provider had not assessed risks posed to people by the environment. Shortfalls in the fire safety precautions had been identified following the last inspection in March 2015 by Kent Fire and Rescue Service (KFRS). The KFRS made several recommendations to ensure the fire safety systems were effective. There were still outstanding recommendations and requirements from the KFRS. The provider did not have an understanding of the key risks and challenges of the home. They had not carried out audits and checks to make sure the home was safe. Risks and hazards to people posed by the environment and equipment had not been checked since April 2015. The registered provider had not given the manager or staff any information about the identified risks found at this check. No action had been taken to address the shortfalls that had been identified in April 2015 and following our previous inspections.

A system to recruit new staff was in place. This was to make sure that the staff employed to support people were fit to do so. However, all the checks that needed to be carried out on staff to make sure they were suitable and safe to work with people had not been completed by the provider. One staff was from overseas, outside of the European Union, there was no evidence that they were in the UK legally.

Staff did not all have the skills and competencies needed to give safe, good quality care and support. Staff were not regularly supervised and had not had a yearly appraisal. When concerns had been raised about the conduct of a staff member no action had been taken to make sure their practise was safe. The induction was not thorough and some staff had not completed it. Staff had not received the all the training they needed look after people safely. Staff had not all received training in protecting people from abuse. Staff knew what abuse was and said they would report to the manager. Some staff did not know that they could report abuse or suspected abuse to outside organisations like the local social services safeguarding team. The manager was not fully aware of their responsibilities about safeguarding people from abuse.

There continued to be imposed restrictions that had not been assessed, consented to and reviewed to be the least restrictive option. People were deprived of the liberty, as the external doors were locked, with no assessment and agreement to make sure this was lawful.

We found a number of breaches and persistent breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took urgent enforcement action against Macari Homes Limited to protect the health, safety and welfare of people using this service and cancelled the provider's registration with immediate effect.

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?

Inadequate

The service was not safe.

Risks to people had not been identified and assessed. The staff did not take action to keep risks to a minimum and did not contact the doctor when people's health needs deteriorated.

When risks to people had been identified guidance to reduce the risks had not been followed. People were at increased risk of choking, falling, developing pressure sores and of malnutrition and dehydration due to the poor practice.

People were at risk of receiving inappropriate care and support. Care plans and risk assessments were not up to date including when peoples' needs had changed. Staff did not have up to date information about people to give safe care and support.

People were at risk of not receiving the care and support that they needed as there were not enough staff on duty. The recruitment checks for staff working at the home were not thorough.

People were not protected from harm if there was a fire or other emergency The provider had not meet recommendations and requirements made by the Kent Fire and Rescue Service. Other risks and hazards to people posed by the environment and equipment had not been checked to make sure they were safe.

People were at risk of not having their rights upheld if they lacked capacity or had fluctuating capacity. The provider did not have a system to assess people's ability to make specific decisions where it had been identified that they may lack capacity.

Springfields Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 26 June 2015 and was unannounced.

The inspection was conducted by an inspector and an inspection manager.

We usually ask the provider to complete a provider Information return or PIR. Because we carried out this inspection at short notice we did not have a PIR.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority and safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with or observed most people living at the home. We spoke with the provider, the manager and four staff. We spoke with two relatives or visitors; we had information from the local authority case managers, commissioning officers, visiting nurses and the safeguarding team.

We looked at records relating to three care staff, four care plans, audit and monitoring records, medication records, staff rota, policies and procedures and training records.

The last inspection was carried out on 11 and 12 March 2015 when we found several breaches of regulations which had major impact on people at the home. We are taking enforcement action against the provider.

Inadequate

Is the service safe?

Our findings

Most people at the service were not able to tell us or indicate if they felt safe. Some people appeared to be relaxed and content, but others, at times, looked unhappy or were distressed. One relative told us, "He is being provided for but not cared for and there is a big difference". A relative said that people did not get enough stimulation or attention. They said that staff were very rushed and did not have time to do things. Relatives told us that they had reported concerns but no-one took any notice. Staff told us they were often short of staff and that there were no arrangements to cover the shortfalls including sickness. Staff said they were often rushed and did not have time to sit and talk to people.

On the first day of the inspection a person was sitting in the lounge and was visibly upset and was sobbing. A member of staff came into the lounge with a hoist to assist another person to move to the dining room. A second staff member entered to help with the hoist. Neither staff talked to or looked at the person sobbing, neither offered any comfort.

On the second day of the inspection a person was observed sitting in a wheelchair in the dining room on their own. They were sat facing a wall. Staff had taken them there at some point. The person sounded upset and distressed. There were four people in the lounge area. There was no staff in the lounge or dining area. When staff did arrive they said the person was in the dining area as they were waiting for their lunch. The time was 11:30am lunch was not served till after 12 noon. When this was pointed out to the staff they took the person into the lounge area were they settled quickly and became more content.

The provider did not ensure that people were treated with dignity and respect. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were not thorough and did not follow the provider's own recruitment policy. On the first day of the inspection there were three care staff on duty from 8am. The manager arrived just after 1pm. We checked the staff files of the three care staff on duty. The staff file for the staff member who was in charge that morning had very little information. The staff member was from overseas, outside of the European Union. There was no proof of identity or passport, no Visa, no evidence that the person was in the UK legally, no references or criminal background check. The provider was the staff member's 'sponsor' as required by immigration law and there was no Certificate of Sponsorship as required. The provider said she had the documents relating to this staff member elsewhere so we asked her to send us the information. Care Quality Commission (CQC) did not receive the documents from the provider.

There was only one reference for a second staff member instead of the required two references in line with the provider's policy and no criminal background check. There was no criminal background check for the third member of staff. Shortfalls in the recruitment process were found at the last inspection of March 2015.

Staff raised concerns about a staff member's conduct to the manager and to CQC. The manager met with the staff member to talk about the concerns and there was a record of this conversation. There was no record of what action was taken to ensure people's safety, the staff member continued to work with people unsupervised. At the last inspection the same situation had occurred. Staff raised concerns to the manager about some staff's practice yet staff continued to work with people unsupervised without any extra safety measures in place.

This was a breach of regulation 19(1) (2) (3) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the manager had been given a dependency tool to work out how much support each person needed. This tool rated people's needs as low, medium or high and then allocated hours of staff support. The manager had completed the tool which showed that 45 hours of support were needed each day to meet people's needs. This level of support was not being provided. The manager said when three care staff were on duty during the day 33 hours of support were provided. The last two weeks rotas showed that there were never any more than three care staff on duty and there had been times when only two care staff were on duty. Four people needed the support of two care staff so there were occasions when the two staff on duty were supporting one person leaving the other nine people without supervision and support. Some people were at risk of falls and of choking so needed staff supervision and support at all times.

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Is the service safe?

On the first day of the inspection there were three care staff on duty from 8am. The manager arrived just after 1pm. There were occasions when the two care staff on duty were a new teenage member of staff, who had not completed induction training, and a staff member who was on light duties due to a medical condition. This staff member was restricted in what support they could offer and were unable to use the hoist to move people safely. There was a daily 'allocation sheet' which allocated staff names to bedrooms numbers and to 'medication and laundry'. The allocation sheets for 17, 18, 19, 20, 21 June 2015 recorded the names of only two staff on the shifts for those days. Staff told us that the rota was not planned and written very much in advance so they did not know what shifts they would be working from week to week. The second day of our inspection was a Friday, the rota for the following week starting on Monday was not available, the manager said she had not finished writing it yet.

There had been some staff sickness at short notice with no contingency to cover this. The manager and staff told us that they were prevented from calling in temporary staff from an agency by the provider because of the cost. No agency staff had been used to cover the staff shortfalls. The manager stepped in on occasions to help the care staff but this was not ideal as this left no one to cover the management duties including monitoring and checking and the day to day management tasks.

There were periods of time when there were no staff present in communal areas to supervise people and people in their rooms spent long periods of time without seeing the staff. One person seated in the lounge had pressure relieving footwear around their feet. They were trying to remove these and said "I am trying to get out of here and I can't." They loosened the footwear around their feet but did not remove them and tried to stand. The inspector alerted staff to this as there were no staff around and the person was at risk of falling.

The provider had failed to ensure there were enough staff on duty to meet people's needs. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of regulations at the last inspection.

Staff did not have the skills and knowledge to meet peoples' needs. We looked at the training plan and training records relating to the staff members on duty. One staff member had been working at the service for a few weeks. The qualifications section on their application form was blank. They had only completed 3 units of 8 units of an induction; units relating to how to safeguard people from abuse and about dementia had not been completed. There was one certificate in the staff member's file for first aid training dated 27 June 2014 and no other proof of qualifications. The staff member had not attended any training since starting work at the service.

There had been no safeguarding adults from abuse training this year. Not all staff members were included on the training plan and not all staff had attended training in how to move people safely even though four people needed to be moved by staff.

Staff should have regular one to one meetings or supervision with a more senior staff to talk about any issues, training needs and to gain support and coaching. The provider's policy was that staff had a supervision meeting at least six times a year and a yearly appraisal. Staff were not supported and supervised to make sure they were providing good safe care. One staff had not had a supervision meeting with a line manager this year, the second staff had supervision meetings in January and May 2015 and the third staff had had only one meeting.

The provider had failed to train and supervise staff. This was a breach of regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was a breach of regulations at the last inspection.

People were at risk of not receiving the medical interventions they needed as staff did not recognise when a person medical condition was deteriorating and did not take action until prompted by the inspectors. People were at risk of developing further discomfort, pain and potential risk of bladder, prostrate and kidney problems as staff did not have the skills, knowledge and competencies to recognise when a person health was deteriorating.

One person had not passed urine for 20 hours. Staff said that the person had on several occasions tried to pass urine but could not. This was not reported to the manager by the staff. The inspectors identified this as a concern and requested that the manager contact a doctor. The manager did not do this immediately and it was left for another hour until they were asked again by the inspectors. The person was seen by a doctor that afternoon and subsequently taken to hospital, where they were diagnosed with urine retention and had to undergo a medical procedure.

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Is the service safe?

Some people were at risk of their skin breaking down and they required equipment like special cushions and mattresses to help keep their skin healthy. The provider had not taken sufficient action to reduce the risks of people developing pressure sores.

One person had a foam pressure reliving mattress called an overlay mattress. These mattresses were thin about two inches thick and should be placed on top of a normal mattress to reduce the risks of people developing pressures sores. This overlay mattress had been placed directly onto the base of the bed. When the inspector sat on this mattress it sank straight to the hard wood base and it felt like you were sitting on wood. District nurses said that the impact of sleeping on the overlay mattress without the support of a normal mattress would increase the risk of the person developing pressure sores. Another person was at risk of developing pressure sores as their mobility had recently reduced. They were waiting for special airflow mattress to be delivered. In the meantime they should have had some pressure relieving mattress on their bed. There was an overlay mattress under the person's bed. The manager said this was put on the floor at night in case the person fell out of bed. When asked if there was another overlay mattress that could be used for the person while they awaited the arrival of airflow one, the manager said she thought there was one somewhere but this had not been placed on the person's bed.

Staff told us they regularly ran out of supplies of incontinence pads. Some staff brought in pads they had purchased with their own money. Without the right continence aids people were at greater risk of their skin breaking down leading to pressure sores. This was an issue at the last inspection.

Some people were at risk of falling over. One person had been identified as being at increased risk of falls as their mobility had reduced but they did still try to stand and walk. The person was in their bedroom. They had one shoe off and one shoe on. One leg of their trousers was caught round their left foot. The person tried to stand using the arms of the chair. At this point their trousers, which were too large for them, started to fall down. If the person had tried to walk the risk of them falling would have significantly increased due to them being inappropriately dressed. There was an alarm mat under the person's bed. Alarm mats were used to alert staff if a person did stand up and try and mobilise. This was not being used so that staff would not be alerted if the person did stand up and try to mobilise when they were in their bedroom. Their bedroom was away from the lounges and communal areas and the lack of sufficient staff meant they were left unsupervised. The staff said the alarm mat was only used at night. On the second day of the inspection the alarm mat was placed by the persons feet, however the person still had the same trousers on that were too big and falling down when they stood up. The person's mobility had improved and they were able to walk with the support of staff and a walking aid. The staff member told us that the trousers did fall down when the person stood up, but she just 'hung on to the back of them while they were walking'. The person's care plan and risk assessment had not been updated to reflect the changes in their mobility and how staff should safely support them to mobilise.

At the last inspection the provider had not assessed the risks associated with fire. Providers must comply with the Regulatory Reform (Fire Safety) Order 2005. Under this order providers must provide people, staff and visitors with relevant information on the risks to them identified by the fire risk assessment, inform them about the measures the provider has taken to prevent fires, and how these measures will protect them if a fire breaks out. Providers must consult staff about fire precautions and protect people and visitors by providing information about fire procedures. Following the inspection of March 2015, we referred the service to the Kent Fire and Rescue Service (KFRS). The KFRS carried out an inspection of the premises and fire safety precaution on 12 March 2015 and returned at the end of April 2015. The KFRS made several recommendations and requirements to ensure the service was safe in the event of a fire. There were outstanding requirements from the KFRS inspection including the need for a new fire panel which controls the fire alarm system.

At the last inspection the provider had not assessed the risks to people from electrical installations and equipment. The Electricity at Work Regulations 1989 requires providers to check the safety of the electrical installations including the hard wiring of the service. The hard wiring should be checked in care homes every five years. The last check of the hard wiring was carried out on 7 September 2007 and was 'unsatisfactory' with a list 29 recommendations of 'urgent remedial work' needed. The provider said the work

Is the service safe?

had been completed but could not provide evidence that the urgent work on the electrics had been carried out. The provider showed us a quotation for the work but no paid invoice or hard wire test certificate.

Risks and hazards to people posed by the environment and equipment had not been checked. This was the case at our last inspection. Since then the manager said she had carried out regular checks but the last check recorded was 'April 2015' so no recorded checks for May or June 2015. The provider told us that she had arranged for a consultant to carry out checks and showed us her mobile phone with an attachment to an email dated 27 April 2015. The provider had not printed off the attachment from her mobile phone to show the manager and the staff to make sure any actions were followed up.

The provider had failed to provide care and treatment in a safe way. This was a breach of regulation 12 (1) (2) (a) (b) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not having their rights upheld if they lacked capacity or had fluctuating capacity. At the last inspection there was a breach of the regulation relating to consent. The provider did not have a system to assess people's ability to make specific decisions where it had been identified that they may lack capacity. There were still shortfalls in the systems to assess people's ability to make a decision and to give consent. Some people at the service had dementia and lacked capacity. Because of this it was important that staff knew about the principles of the Mental Capacity Act 2015. We asked the provider and the manager to tell us about the principles of the Mental Capacity Act 2005. They did not tell us much at all, they lacked awareness of the principles of the Act and their responsibilities under the Act.

The provider had failed to obtain consent from the relevant person for care and treatment. This was a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of malnutrition and dehydration. Some people had lost weight. One person had lost 1.3kg in one week. The person was elderly and frail and had underlying health problems so this was a significant amount of weight to lose in one week. The provider had taken no action to support the person; there had been no referral to a doctor for advice in response to the significant weight loss. The lack of a response to weight loss was found at the last inspection.

Some people needed special diets. One person was at risk of choking and had been assessed as needing a 'pureed diet'. The person's care plan stated they needed supervising by staff while eating at all times due to their risk of choking. The person sat alone in their bedroom away from the kitchen and main lounge area. On the first day of the inspection the person was given a hot meal at lunchtime of casserole and dumpling with vegetables. The meal was not pureed and the person was not supervised by staff. Staff told us they had not been supervising the person while they ate and records confirmed this. With times when only two care staff were on duty and considering the layout of the service, if this person did choke there was a risk that staff may not be aware and may not be there in time to give support.

Some people were at risk of dehydration. Staff were supposed to be monitoring the amount of fluids that people were drinking but the records had been inconsistently completed and indicated that people were not having enough to drink. There was no guidance for staff on how much people should be drinking and what action they should take if they were not drinking enough. The amount of fluids people drank each day was not totalled up to see if they had drunk enough. In one person's fluid intake record nothing had been recorded for 20 hours. Some people had their meals and drinks in their bedrooms. Drinks had been placed on their tables but they were placed out of people's reach. One person, who was blind, had a drink placed at the end of their table which was out of their reach and they did not know it was there.

The provider had failed to ensure that the nutritional and hydration needs of people were met. This was a breach of regulation 14 (1) (2) (b) (4) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a breach of regulations at the last inspection relating to the provider not assessing and managing risks to people and not reducing the risks of malnutrition and dehydration.

Inadequate

Is the service safe?

As at the last inspection care plans and risk assessments were not all up to date even when peoples' needs had changed. Staff did not have up to date information about people to give safe care and support.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not ensure that people were treated with dignity and respect. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information was available as required by Schedule three of the Regulations before new members of staff started work. This is a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to train and supervise staff. The provider had failed to ensure there were enough staff on duty to meet people's needs.

This section is primarily information for the provider

Enforcement actions

This is a breach of Regulation 18 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of regulations at the last inspection.

The enforcement action we took:
We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to provide care and treatment in a safe way. This was a breach of regulation 12 (1) (2) (a) (b) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had failed to obtain consent from the relevant person for care and treatment. This was a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.

Regulated activity	Regulation
	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Enforcement actions

The provider had failed to ensure that the nutritional and hydration needs of people were met.

This was a breach of regulation 14 (1) (2) (b) (4) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action and cancelled the provider's registration with immediate effect.