Hatzfeld Care Limited

Spring House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 23 November 2017. The inspection was unannounced. At the last inspection in March 2017 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in Regulation 12 Safe Care and treatment and Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection we requested an action plan from the provider which they provided.

At this inspection we found continued breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because the service had not kept people safe and was not effectively monitoring the quality of the service. We also found additional breaches of Regulations 11 Need for Consent, Regulation 13 Safeguarding service users from abuse and improper treatment and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Spring House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 21 people in one adapted building. There were 17 people resident at the care home when we inspected.

There was a registered manager employed at this service. 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.

Risks to people had not been identified resulting in concerns being raised with the local authority safeguarding team by CQC. Other concerns had been raised by visiting professionals. Staff were trained in safeguarding adults but had not identified or reported concerns.

Staff recruitment procedures were robust. However, there were insufficient numbers of staff on duty to meet people's needs safely. One to one planned care had not always been provided.

Servicing and maintenance of the environment had been carried out in a timely manner except for the servicing of one lift.

The provider had not ensured training was up to date for all staff and staff knowledge and skill in dealing with behaviour that challenged them was only completed by half of the staff. People were not always protected by competent staff.

People were not always supported to have maximum choice and control of their lives and staff had not supported them in the least restrictive way possible; the policies and systems in the service were clear and supported this practice. Staff had not followed the correct process for making best interest decisions in line

with company policy. In addition staff had restrained people by locking them in their rooms.

People's nutritional needs were not always met and records to support people's nutritional needs were incomplete.

Staff were described by people as being caring and we saw some positive interactions between people and staff. However, some people were not supported appropriately by staff.

Activities took place but were not always meaningful to people living with dementia. We had recommended at the last inspection that activities were developed further but could see little evidence of progress at this inspection.

The environment had some areas that were dementia friendly but others did not fully meet the needs of people living with dementia. The outdoor space was dementia friendly and allowed people to walk freely and safely.

There were no recorded complaints despite two complaints been made. There were no records of actions taken.

The quality assurance system was ineffective. Audits had been completed in some areas but did not have information about actions to be taken or any learning.

There had been a lack of effective leadership and management at the service which had led to deterioration in the quality of the service. We asked for assurances from the provider that staffing would increase and people would no longer be looked in their rooms. The provider has given their assurance.

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

This service was not safe.

There was insufficient staff working to meet people's needs safely. They did not always have the skills and knowledge required to keep people safe. People who had been assessed as needing one to one care did not always receive that support.

Staff and managers were not clear about their responsibilities with regard to safeguarding people and some incidents had not been notified to the local authority.

People had been restrained by staff locking them in their rooms with no decision making having taken place with professionals or families.

Some areas of the service posed a risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive appropriate training or have their practice checked to enable them to provide effective care for people, particularly where people's behaviour challenged staff.

Staff were notable to demonstrate a clear understanding of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People's nutrition and hydration needs were not always met.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff were caring and we some positive interactions between people who used the service and staff but other people's support needs had not always been considered by staff.

Staff did not always respect people's dignity.

Staff had not always encouraged people to retain skills and independence leading to deterioration in one case.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place outlining people's care and support needs but these were not always detailed..

Activities for people were not consistent and there was little evidence of one to one support for people.

People had raised complaints with the service but these were not recorded so no actions were seen.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in post but feedback about the support staff received from management varied. Staff did not always feel supported or listened to.

The quality monitoring of the service was not effective. Although some audits were completed they did not have associated action plans and no learning from the outcomes of these audits was taking place.

Spring House Residential 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.

The inspection was prompted by a concern raised by a relative. The information shared with CQC indicated potential concerns about the management of medicines, staffing levels and whether or not the provider was working within the principles of the Mental Capacity Act 2005. East Riding of Yorkshire Council (ERYC) safeguarding team visited the service to investigate the concerns and told us they had concerns for people's safety. The issues they had identified were people losing weight, staff not alerting the local authority of safeguarding incidents, restricted visiting times and inadequate staffing levels. We made a decision to carry out the inspection earlier than originally planned.

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This inspection took place on 23 November 2017 and was unannounced.

The inspection team consisted of three adult social care inspectors and one expert by experience with experience of older people and dementia care. 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 the inspection we reviewed all the information we held about the service including notifications. Statutory notifications are documents that the provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider had completed a Provider Information Return (PIR) prior to their last inspection in 2015 and we had not requested an update. The PIR 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. We also reviewed information from a complainant and from the local authority. We used all this information to plan the inspection.

During the inspection we looked around the communal areas and people's bedrooms and spoke with five people living at the service and four relatives. We also spoke with the registered manager, deputy manager, care manager, administration manager, six care workers, the cook and two maintenance workers. We observed medicines been administered and observed lunch time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed care plans and documentation relating to the care for five people and reviewed their medicine administration records (MARs). We also looked at documents relating to the management of the service such as meeting minutes, quality assurance systems and servicing and maintenance records.

Following the inspection we received further concerns from seven whistle-blowers in the form of a letter. We spoke with a member of staff to gather further feedback. In addition, we met with the provider and the registered manager to discuss these concerns further.

Inadequate

Is the service safe?

Our findings

At the last inspection in March 2017 we had identified that people were not safe because staff had not ensured that people's medicines were managed appropriately. This had resulted in a breach of Regulation 12 Safe care and treatment.

At this inspection we found that there was a continued breach of Regulation 12 and a breach of Regulation 13and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Although medicines were now managed safely risks to people had not been identified and acted upon, infection control measures were not in place, safeguarding matters had not always been addressed in line with local protocols and people's behaviours were not managed appropriately. There was insufficient numbers of properly trained staff available to meet people's needs.

We had received one complaint from a relative which we referred as an alert to East Riding of Yorkshire Council (ERYC) safeguarding team. The local authority visited the service to investigate the alert and found the claims to be true. They also identified incidents that had not been reported as safeguarding alerts such as injuries resulting in admission to hospital and unexplained bruising. Staff were not following company or local procedures to report and manage concerns and allegations of abuse although they had recorded the incidents in the service. These policies were in place to ensure the correct management of any allegations of abuse. All the staff we spoke to could tell us about different types of abuse and we saw that training had taken place but was out of date for some people. One member of staff told us, "I would tell [registered manager] and if there was no action would take it further." This had not happened in a number of cases and it appeared that managers and staff did not fully understand their responsibilities in relation to safeguarding people.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safeguarding service users from abuse and improper treatment.

Since the initial alert made to ERYC by CQC on 30 October 2017 the local authority had made several visits to Spring House to investigate the allegations made. They had identified further concerns and when they shared their report with us dated 6 December 2017 they had concluded that two allegations of neglect were substantiated which meant that they had happened. Other local authorities and Clinical Commissioning Groups (CCGs) who pay for people's care at the service are now reviewing people's care and where it is necessary working with people and their families to make sure they are living where they would receive the care appropriate for their needs.

When asked if they felt safe living at the service everyone we spoke with said they did with one person commenting, "Everybody knows everybody." One relative we spoke with said, "Yes, everyone is around; staff on hand. I have seen staff with others and it is nice." However, a second relative said, "No, because of the stairs." We saw that the staircase leading to the second floor was steep and the width had been affected by an unused stair lift in place making it impossible for two people to walk side by side. This meant people who needed support had to have someone in front or behind them as they walked up or down stairs. We

observed that the staircase was dangerous for some people but were told by the deputy manager that everyone on the top floor could access the staircase safely.

The provider had a robust system for the recruitment of staff. We looked at recruitment records for four staff. References had been collected and Disclosure and Barring Service (DBS) checks completed on the background of prospective staff. DBS checks help employers make safe recruitment decisions and help prevent unsuitable people from working with vulnerable groups. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We had serious concerns about the numbers of staff on duty as we had seen that people's needs were not always met. There were a high number of hours for one to one support required at the service and being paid for by the appropriate CCGs or local authorities. These hours were not being provided in all cases.

We saw people left in bed. One person was laid naked on the bed with wet sheets thrown on the floor. Three people were left in bed all day and one person was not up until after lunch. These people missed meals and one had lost weight. Another person who had been mobilising could no longer do so unaided. There were 17 people living at the service all of whom required at least two care staff to provide personal care and support ; there were three care workers providing personal care when we arrived.

We saw that two people were identified as needing three to four staff for personal care interventions on occasions. Later in the morning a fourth care worker arrived telling us their shift was planned but we saw more staff kept arriving during the morning which did not appear to be planned. The care manager told us that this level of staffing was planned but staff told us they had been told to come to Spring House that morning. One staff told us, "I never know where I am working nowadays." When we read the minutes from a staff meeting on 26 October 2017 we saw that the staffing levels had been discussed and staff had expressed concern. The deputy manager had said, "We know it's hard at the moment, we know we need staff and we are trying."

We were provided with information by the service showing the number of one to one hours provided in addition to people's planned care. We observed one person receiving one to one care during the afternoon but others identified did not get the one to one care that had been planned and commissioned. ERYC told us that on one visit to the service they identified that six people should have one to one care but there were only four staff on duty. We saw from rotas that there were usually three or four care workers during the day with a care manager and deputy manager. During the night the rotas showed two or three care workers working which meant that it would not be possible to meet everyone's assessed needs effectively or safely.

We asked people whether they thought there was enough staff on duty and they told us, "Yes, they come and talk with me." Relatives told us they believed there were enough staff on duty. When we spoke with staff some said there was sufficient staff but others disagreed. A letter signed by seven staff that we were told was going to be given to managers was shared with us. It said, "Certain residents require three to four members of staff to ensure their needs are met effectively and this is not possible with the current structure of the staffing and staffing levels." It went on to say, "At times the floor [lounge and dining room] is left completely unsupervised due to having to give said residents their care which is unsafe and unacceptable." These comments reflected our own findings. .

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

One care worker discussed their fears with us saying they did not feel sufficiently well trained to deal with

the levels of behaviours displayed by some people and felt unsafe. Some people living at this service displayed high levels of verbal and physical behaviours which required staff to have specialist knowledge and skills. Only nine out of eighteen staff had received training in managing behaviours that challenged them and agency staff were not trained in these areas. We saw that some call bells were not working which posed a risk to staff if they were in need of support as they would be unable to call for assistance. The provider had not ensured that all staff could effectively and safely manage people's behaviours.

Staff were locking people in their rooms during the day and overnight. The deputy manager unlocked doors as we looked around the service and we saw that people were in the bedrooms. The deputy manager locked the bedroom doors as we left each room. They did not check with people to ask if this was what they wanted to happen. This appeared to be linked to a lack of staff as we were told by staff it was for people's safety. This practice was unacceptable as it put people at unnecessary risk particularly in the event of a fire or other emergency. In addition when we checked fire safety records we saw that although staff had completed fire safety training there were no records of fire drills recorded. This meant that staff would not have been able to practice what they would do in order to get people to safety in the event of a fire. We wrote to the provider asking for assurances that the practice of locking people in their rooms would stop immediately which they gave. We also sought assurances from the provider that staffing would be reviewed in line with people's needs. They confirmed plans to increase staffing immediately.

We observed that areas of the service posed a risk of infection to people. In the laundry we saw that a pile of washing had been left on the floor. Red bags containing soiled items had been left laid on the floor. There was a mop laid on the laundry floor. The door was open and in the adjoining area staff had left their coats and bags. Linked to this area was the staff toilet. The layout and state of the laundry meant that items belonging to staff could become contaminated from the laundry posing a risk to people.

As we looked around the service we saw that there were areas of concern regarding cleanliness. We saw a soiled continence aid in a bag on the floor of one person's bedroom, one person laid on a bed with a sheet wet with urine and another sheet wet with urine on the floor. In one room there was a dirty stained toilet, a bin that was overflowing and a men's urinal on the bedroom window sill. One person was using a machine requiring the use of face masks and had a nebuliser. They both had dirty masks attached. The masks, hoses and tubes should be cleaned or wiped down daily to prevent a build-up of bacteria.

In one first floor bedroom two people were being nursed and staff had personal protective equipment (PPE) provided to reduce the risk of infection. We observed one care worker remove the apron and mask after leaving the bedroom but they went into other areas of the service wearing the gloves until they eventually removed them on the ground floor. This increased the risk of infection spreading throughout the service.

Risks to individuals had not always been identified correctly or detailed in care plans. Risk management plans had not been put in place. This meant people were sometimes at risk of avoidable harm because staff were not aware of the particular risks associated with their care. For example, one person's care plan said they could lock their bedroom door unaided. Staff told us that they locked the person's door and the deputy manager confirmed this. The person's visitor told us that this person could only use one arm effectively and would be unable to lock the door as their dementia was so advanced they did not have the skills to do so and our observations confirmed this. This meant that staff were not correctly identifying risks to people. No-one had risk management plans in place in relation to being locked in bedrooms.

The administration manager told us that, "Accidents are collated monthly and emailed to the directors." We saw that accidents and incidents were recorded but they were not always reported to ERYC safeguarding team when people were injured. The accidents had not been analysed and preventative measures identified

to prevent reoccurrence of these incidents.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

We spoke with the maintenance team who told us that they carried out checks and made repairs at the service. Completed log sheets showed when tasks had been completed. External contractors carried out electrical and gas safety checks, as well as servicing of the fire safety systems.

At the last inspection in March 2017 we had concerns about the management of medicines. Prior to this inspection one relative had expressed concern to CQC because they believed their relatives medicine may not have been administered. However, when we checked that person's medicine administration record (MAR) we saw they had received medicines as prescribed. We observed medicines being administered and checked the management of medicines and found that they were safe. One relative told us, "She seems and looks a lot better, they have got the right balance of medications - all okay."

We looked at five Medicines Administration Records (MARs) which were completed fully. We spoke with a senior carer responsible for medicines who explained that only staff that were trained were allowed to administer medicines. Medicines were stored securely and access was restricted to authorised staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely.

Refrigerated medicines and daily temperatures had been recorded although the maximum and minimum temperatures over 24 hours had not been recorded daily as recommended by The Royal Pharmaceutical Society guidance 'The Handling of Medicines in Social Care'. This would help identify if the temperature of the fridge had gone out of the recommended temperature range and allow staff to identify any issues.

Some people were prescribed medicines to be taken when required, or 'PRN'. We found there was supporting information printed on the MAR to guide staff how to administer these medicines safely.

Requires Improvement

Is the service effective?

Our findings

When we asked people whether or not they felt the staff had the right skills they said, "Yes they have" and, "They are on the ball straight away." However, we found that not all staff training was up to date and did not allow staff to adequately meet people's needs particularly when their behaviour challenged staff. For example, care plans told staff they should use their specialist training to respond to any challenges presented. However we found that only nine out of 18 staff had completed this training so not all staff had the knowledge and skills required to deal with the identified challenges. Training was carried out using an online system.

All the staff we spoke with told us they had completed an induction when they started working at the service. However, one care worker told us that, "New staff are meant to shadow us but they are put straight on to the rota." This meant that new staff did not always have enough time to get to know people and their needs and also learn skills from more experienced staff.

Training was carried out online and subjects such as fire safety, moving and handling, mental health awareness, safeguarding, health and safety and infection control were considered to be mandatory training for all staff. One care worker told us, "Staff need training in handling and managing challenging behaviours. It is new to us; just over the last six months the number of people admitted with challenging behaviour has increased." The lack of this training meant that not everyone was aware of good practice guidance. Good practice underpins the support people should receive and where staff lack knowledge and skills there is a risk of increased behaviours that challenge. The registered manager told us that they had planned training in this subject.

Sensory awareness and dementia care were subjects covered in the online training. One care worker returned to the service after completing a course with an external provider in dementia awareness and told us the course would benefit their practice.

The registered manager told us that staff were supervised and their work checked to ensure that they knew what they were doing. Some of the staff had received supervision but others told us that they had not had any supervision for a number of months. One care worker said, "We are supported by the deputy manager and care manager but I haven't had my supervision for a few months now."

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was

working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met

People's plans of care showed the principles of the MCA Code of Practice had not always been used when assessing their ability to make some decisions. The service had a policy and procedure on the MCA and DoLS designed to protect people. However, when we spoke with staff we realised that they did not fully understand the principles of the MCA. Best interest decisions are made when someone does not have the mental capacity to decide on their care and treatment. Decision making should include family, friends and relevant professionals in order to find the best outcome for a person. The service had followed this process when applying for DoLS but not in all other cases. For example, in one person's care plan it was identified that one person required a sensor mat to detect movement; No best interest decision had been made. One person was left in bed, "To wake naturally" but this sometimes meant not waking until the afternoon. There was no best interest decision recorded to show how this decision had been reached. They also had a sensor mat with no best interest decision recorded. None of the people who had locked doors had best interest decisions recorded.

Not all of the staff we spoke with could explain to us what they understood by mental capacity and deprivation of liberty safeguards. One care worker said, "DoLS tell us what care they [people who lived at the service] require, to make them comfortable and cared for even if they do not agree to it. I haven't been involved in a best interest's decision" and a second said, "If a client is on a DoLS and have been incontinent during the night, then it is the responsibility of the staff to ensure resident is cleaned and assisted in full personal care in their best interests." This meant that people lacking capacity may not be protected because understanding of the legislation and guidance was not clear for all staff and the guidance had not been followed in all cases.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Need for Consent).

The registered manager told us they had applied for a number of DoLS authorisations, and nine had been granted. Other applications had not yet been assessed by the local authority.

Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures.

People's nutritional needs were not always met. People who used the service gave us positive feedback about the food they received. Their comments included, "Food is good enough" and, "Good, chicken dinner today was good, they bring what I like and I get enough."

Relatives feedback was varied with one person saying, "Food looks nice, [relative] is eating well; never ate before" in contrast with a second relative who said, "I don't think [relative] is eating well, they have lost a lot of weight."

We observed people dining at lunchtime. There were two areas where people could sit and eat at tables but there were not enough places for everyone. We were told that some people liked to sit in their armchairs in the lounge area or stay in their rooms. People were encouraged by care workers to sit at tables and were asked where they wanted to sit. There was no menu displayed so that people could choose what they wanted to eat and people living with dementia were not shown the meal options. The cook told us, "People do not get asked what they would like as people forget, but I follow their likes and dislikes." We saw that people had a variety of meals which supported the comments of the cook.

There were sufficient staff to support people and assist them to eat during lunch time on the day we inspected but when we checked the rotas these numbers were not usual and had not been the case on other days. Care workers sat with people when they required assistance to eat and drink. People were provided with plate guards to assist them in retaining their independence and skills when eating. .

Some people's food and fluid intake was monitored. Charts showed that some people had no food or drinks during the morning because they were recorded as sleeping and after 6pm people had no records of food and drink. Some people had experienced some weight loss and so it was important that they did not miss meals. Fluid intake was very low for some people which increased the probability of a risk of dehydration. Where people had issues with their weight we did not see any referrals had been made to the GP or dietician. We saw that one person had lost over one stone in weight over 9 months but no referral had been made.

Although the environment did not fully support the needs of people living with dementia there were areas of good practice. There was a fully accessible outside space where people could walk freely and safely. This was a large garden where raised flower beds had been planted. There were continuous paths around the garden and it was enclosed making it safe. One person had developed a vegetable garden which they tended themselves. The cook told us they used some of the produce. There was a large outside cabin where people could spend time. The work on this cabin was not fully completed but the space was comfortable and provided a quiet space away from the main house.

Inside the main house people's bedrooms were in corridors away from the main lounge and dining room apart from one person's room which opened on to the communal area. There was an open plan lounge/day room with an attached small conservatory with a separate small dining room. This was a noisy area. Memory problems can become more apparent in people living with dementia if they are distracted by noise.

The floors in corridors were of a wooden look material contrasting with walls. Door frames had been painted in contrasting colours to make them distinguishable for people with visual or cognitive impairment but had no pictures or means of identification for people.

There were some pictures on the walls set low enough for people to be able to look at them but no clear signage with pictures and words. Disorientation and bewilderment are a common experience for people with dementia. Signs can be very helpful if they are clear, mounted low enough, have words and a picture and contrast with the background. There were no rummage boxes in communal areas and people did not have access to items which would distract them. A rummage box is a container filled with familiar items as a means of reminiscence. It helps people with dementia feel secure through access to familiar items and can be used as an activity, as a distraction technique and therapeutically as a reminiscence tool.

We saw that GPs, district nurses and the community mental health team had been involved in providing healthcare to people who used the service although some people had not been referred for healthcare. Information from health care professionals and GP visits were recorded which meant that communications around people's health were easy to monitor.

Requires Improvement

Is the service caring?

Our findings

People who used the service spoke positively about staff, describing them as kind and caring. One person told us, "[Staff] are alright; friendly and kind" and a second person said, "Brilliant, care is there when you want it." A relative told us, "I am happy with staff, my [relative] always looks nice, and there are never any odours when I visit." A second relative said staff were, "Caring enough."

Staff we spoke with appeared to demonstrate a good understanding of people's needs and preferences and a caring approach towards people who used the service but when we visited one couple in the bedroom they shared we found that they had been left in bed all day, unable to communicate with each other properly. One person had previously been getting out of bed for short periods using a stand aid with no problems. This was no longer the case and a care worker told us, "It is because staff are not following the procedures and no-one is following this up." Prior to the inspection this person had been visited by a physiotherapist and a safeguarding alert had been made to the local authority because of their concerns. The safeguarding has been investigated and all the allegations have proved to be true. Action is now been taken to ensure this couple receive appropriate care and support which meets their physical and emotional needs.

In addition one everyone was living with dementia at the service but communication care plans were brief and did not provide the necessary detail to support staff in dealing with any barriers to communication. For example one person's care plan had no details about the manner in which they currently communicated and words or phrases they may use and what they meant. This would have assisted staff in communicating in a meaningful way.

Staff did not have respect for people's dignity as they had locked them in their rooms without consideration of their wishes or feelings and had not followed the principles of the MCA. One person's bedroom led directly on to the communal areas and they had to be taken through the communal area when they were taken to the bathroom. One care worker told us, "It is not very dignified for [Name of person]. We have to lead him through lounge to get to bathroom and they can be incontinent. It is not dignified."

In some cases staff encouraged people to do things for themselves in order to maintain their independence. One care worker said, "I try and encourage [name of person] to walk more."

Rotas did not allow staff the time they needed to provide emotional support. One to one hours had not always been carried out which would have allowed time to support people as individuals. People had been left in bed for long periods throughout the day without any consideration of their needs. One care worker told us, "A lot of the staff really do care. We try but don't always have the time. This results in poor staff morale and people pick up on that. Staff are not always working at their best."

We saw one care worker supporting a person by dancing with them and giving them a hug." However, in order to encourage the person to dance they turned on the music loudly without asking anyone else if they minded. The loud music affected the atmosphere of the room which no longer felt calm. Staff interactions

with people did not always consider the needs of others when in communal areas.

We visited one person in their room. They were in bed. They told us that other people who used the service sometimes came into their room and took their belongings. When we asked them about living at Spring House they told us "It is alright. I like it here, they are nice people." Their room was personalised using their own belongings, clean and warm. In contrast some people had rooms that were sparse and contained no personal items.

We observed that staff involved people in basic decisions, such as where they wanted to sit to eat their meal, but they were not given a choice of food to eat. One care worker told us, "I give people as many choices as I can." One person was described as having no verbal communication. A care worker told us, "They [person who used the service] can understand what is being said. They communicate through facial expression. [Person] screws up their face if they don't like something. This is also how they express pain. We don't use any cards or pictures." It was not clear how this person could effectively make choices or be enabled to make decisions.

At the time of our inspection we saw that at least one person received advocacy services. Advocates provide independent support to help ensure that people's views and preferences are heard. We saw information about advocacy services displayed for people to read which was not useful to most of the people who used the service as they did not enter that area and the majority would be unable to understand the significance of the notice. However it was useful information for families and visitors.

Although there was an equal opportunities policy staff had not always supported people with diverse needs in relation to equality and diversity. Recently the service had restricted visitors to the service. This was done without consultation with people, relatives or professionals. The registered manager told us they were following advice from a mental health professional but that was not so. The action prevented people from spending as much time with their relatives. On the day we inspected the registered manager gave us a copy of a letter he planned to send to relatives reversing the decision. They told us, "This was an experiment which has not worked."

Requires Improvement

Is the service responsive?

Our findings

The registered provider completed an assessment prior to each person moving into the home and a care plan was then developed. We found that care plans did not always provide detailed information. The care plans related to people's personal care needs, their mental health and well-being, physical health and well-being, medication, finances, nutrition, continence, personal hygiene, mobility, relationships and falls.

Some people displayed behaviours that challenged the staff and their care plans contained guidance on how to respond and manage these behaviours. Some of these required more detail in order to be sure that staff knew how to respond consistently. For instance, specific detailed information about how staff should respond should be included in every case. In addition, the care plans gave instructions to staff such as, 'Staff should use their CPI [control and restraint] training' but only half of the staff had completed this training. This meant that the care plans could not be implemented by all staff which led us to question whether the provider could respond to everyone's needs appropriately.

The registered provider's policy was to review care plans monthly and update them where required. We saw that monthly updates had been completed. We were also told by the administration manager that care plan audits had been completed but found no evidence to show this had been done. Each care plan had associated risk assessments where it was necessary but some of these were not always completed correctly. For example, staff had completed a Waterlow assessment for one person. Waterlow assesses the risk of skin damage for a person looking at a number of factors. We saw that for one person the staff had scored the assessment incorrectly. They had not scored them as having a particular need which we could see from their records they had. This meant that they were scored as 'at risk' of skin damage when in fact they were at 'high risk'.

Staff completed monitoring records in relation to specific requirements, such as repositioning and food and fluid intake, where this was relevant to individuals. These showed a lack of oversight and were not an effective tool. Some people who were at risk of weight loss had no food or fluids recorded as taken during the morning as they had been left in bed. In addition, food and fluids were not recorded as given during the evening and overnight. We could not be sure what food and fluid intake some people had been given. Some people had lost weight and the lack of good recording and oversight meant that staff would be unable to correctly identify particular issues in order to be able to respond with appropriate actions. This left people at risk of malnutrition or dehydration.

Some relatives told us that staff were responsive to people's needs and kept them informed of any changes but one told us that they had arrived at the service to find their partner had been taken to hospital. They had not been informed. Their comments included, "They (staff) let me know if they are unwell or anything" and, "They're very good." However, one relative told us that staff had not responded appropriately to their relatives needs and they had complained to the provider and CQC. This had been investigated as a safeguarding matter.

During our inspection we saw no evidence that people were supported to take part in activities and leisure

opportunities of their choice. We observed staff putting on music and dancing but it was not at the request of the person. The activities board showed no activities arranged for that day when we arrived and a member of staff had told us, "The activities person is on holiday this week so they [people who used the service] are just doing bits here and there." However, later that day a care worker took two people for a trip to the beach. We did not observe any meaningful activity supporting the needs of people living with dementia. There was some social chat as a group, between people who used the service and with staff and visitors who came in and out during the day.

People told us, "I have been to Scarborough and Bridlington in the car, and I watch TV"; "They take me out, we go all over the place"; "I do gardening, I have grown vegetables" and I have been on trips out; I like Bridlington." Relatives told us, "[Name] just wanders around; they did get her out in the garden a few times"; "No, not enough activities; needs more. I am told there is a new activities room but I have never seen [Name] do any activities"; "I come every day to visit but have been asked to leave at certain times. The registered manager did say that I could take [Name] into the garden room but it is not finished so that is not possible."

We recommend the provider research good practice around meaningful activity for people living with dementia.

We had received a whistleblowing concern telling us that there was insufficient staff to provide people with the time they needed. Our own observations indicated that staffing levels did not allow time for individual social support from staff. However, staff did chat to people on an individual basis when they had chance. There was a hairdresser visiting the service on the day we inspected. Whilst some activities were available, it was clear from feedback and our observations, that there was opportunity to develop activities further in line with people's needs and preferences. We had made a recommendation to this effect at our last inspection but activities do not appear to have been developed since then.

The registered provider had a complaints policy and procedure, which was available to people and relatives. There was no record of any complaints received by the service. We were aware that one complaint had been made by a relative and another by a member of staff. Neither of these were recorded. We spoke with the person who told us they had raised a complaint in writing. People we spoke with said, "I have never complained"; "I would tell the carer (pointed to one) – they are always there" and "I haven't done (complained)." A relative told us, "I would speak to any of the staff but I have no complaints" and a second relative said, "I'd approach any staff. I have never complained, but should do as the clothes I see him in are not his."

Nobody we spoke with could recall taking part in residents meetings, but we saw records that showed residents meetings had taken place monthly. We saw that one person's family had attended one meeting. Subjects discussed were food preferences, where people would like to go on trips and planning of events.

Requires Improvement

Is the service well-led?

Our findings

Spring House is one of five services run by Hatzfeld Care Limited. At the last inspection we had some concerns which resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good Governance). At this inspection although we found improvements had been made to medicines management we identified further concerns.

There was a registered manager at the service who had been working for the company since 2016. There had been a lack of oversight by the registered manager who is seen as an area manager overseeing three of the provider's services. They did not have a day to day presence at the service. The service manager has been away from the service and this appeared to be linked to deterioration in practice as staff reported that things had been worse in the last six months. People with very complex needs had been accepted into the service which had an impact on the care provided because of a lack of staff confidence and competence in this area.

We asked the provider for assurances that peoples doors would no longer be locked and that staffing numbers would be increased. They assured us that this was the case and met with us to discuss the issues we had identified. The registered manager had been told by the local authority prior to our inspection that doors were not to be locked but that practice continued when we visited so we could not be sure that actions would be carried out.

The registered manager was present for the inspection and at one stage the inspector had to request that the registered manager left them to carry out the inspection as their presence made it difficult to talk to people privately. The registered manager had made a decision to restrict visiting at the service. We discussed this with the registered manager who showed us a letter they were going to send to relatives about revised changes to visiting arrangements. They told us that the visiting arrangements had not worked and so they were reverting to open visiting times the following week.

There had been a lack of effective leadership and management oversight at the service which was evidenced by the number of safeguarding issues that had been identified at the inspection and by visiting professionals which had not previously been identified by the provider. The provider was not in touch with what was happening at this service.

Some staff told us they felt unsupported by the provider. They felt that the care manager and deputy manager tried to help them as much as possible but told us that the provider and registered manager were not interested in their welfare. They enjoyed working at the service but more recently they had become worried because they did not feel able to appropriately meet the needs of people being admitted to the service due to the lack of knowledge and skill they had in this area of care. We found that the provider had not ensured that their workforce could adequately meet people's needs.

One staff told us, "Management is good and structured well. They offer financial support, don't have favourites; most functional management I have ever worked with. [Registered manager] is always there for

me. They are approachable. Think I have one to ones every couple of weeks. I have faith in them." However, another said, "The managers do not consider the welfare of the staff. I have been assaulted and told that it is part of the job. When we have raised issues with the registered manager they have told us, "If you don't like it [Name of supermarket] are hiring." There is a fear of reprisal if staff raise issues."

Staff and resident meetings were held monthly and surveys had been completed by staff and people who used the service. We saw from staff meeting minutes that although staff concerns were acknowledged at the meetings senior staff had not been proactive in supporting staff in finding solutions.

There was a quality monitoring system in place but it was not effective. We saw that audits of certain areas of the service had been completed but others had not. There were no clear action plans to identify areas for improvement and show the response to the actions. We could see no evidence of learning from audits. The administration manager told us, "As a team we all do the quality auditing." This process was not clearly defined and there were inconsistencies which resulted in a system which did not drive improvement within the service.

We found continued breaches of regulation which further demonstrated that the providers quality monitoring system had not been effective in bringing about the required improvements.

We concluded that the service had not been well led and that the provider had a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

Following our inspection we met with the provider and registered manager and were given a copy of their action plan which they had implemented to start to address our concerns. The provider gave reassurance that the matters raised were being taken seriously and that they were committed to making the required improvements.

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
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users had not always been provided with the consent of the relevant person.Staff had not acted in accordance with the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. Risks to the health and safety of service users receiving the care or treatment were not always assessed and the provider did not do all that was practicable to mitigate any such risks. The provider did not ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; The prevention, detection and control of the spread of infection was not assessed or mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Care and treatment of service users had not always been provided with the consent of the relevant person.Staff had not acted in accordance with the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service user. They did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff. Staff did not receive appropriate support and training to enable them to carry out the duties they are employed to perform.