Springfield House (Oaken) (2001) Limited

Springfield House Nursing Home

Inspection report

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Date of inspection visit:
05 July 2016

Date of publication:
15 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 5 July 2016 and it was an unannounced inspection. Our last inspection took place in May 2015 and we found that some improvements were needed. We found not all principles of the Mental Capacity Act 2005 were followed. Medicine administration records were not countersigned when needed and there was no guidance for staff when people required creams to be applied At this inspection we found some improvements had been made, however further improvements were needed.

The service was registered to provide accommodation, personal care and nursing care for up to 36 people. At the time of the inspection 28 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found there were not enough staff available to support people and they had to wait to receive care. Risks to people were not managed in a safe way and recommendations that had been made to keep people safe were not always followed. Staff did not have time to spend with people and care that was delivered was not always provided in a dignified way.

People did not receive support in their preferred way and there were few activities they could participate in. People and relatives knew how to complain however they did not feel their concerns were actioned. Staff knew how to whistle blow but were not confident they would be listed to.

Quality monitoring systems were in place however these were not always effective in identifying concerns. When concerns were identified action was not always taken to bring about changes. We found care needs were not always recorded accurately to ensure the correct action was taken.

People were supported by staff they liked and who had an induction and training that helped them to support people. They understood about safeguarding and action to take if they suspected abuse. The provider completed checks on staff to ensure their suitability to work with people. People's medicines were stored and administered in a safe way.

The principles of the Mental Capacity Act 2005 were followed and the provider had considered when people were being restricted. People enjoyed the food and when they needed support from health professionals they were referred appropriately. Relatives and friends felt welcomed and were free to visit at any time. People and relatives felt involved with reviewing their care.

There was a registered manager in place and people and relatives knew who they were. They notified us of significant events that occurred within the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
There were not enough staff available for people and they had to wait for support. Risks to people were not always managed in a safe way. Staff knew how to recognise and report concerns or potential abuse. Medicines were managed in a safe way and the provider completed checks to ensure staff suitability to work with people.

Is the service effective?

Good

The service was effective.
The principles of the Mental Capacity Act 2005 were followed and when people may have restrictions placed upon them this had been considered. Staff received an induction and training that helped them to support people. People enjoyed the food and were offered a choice and when needed people received support from health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People were not always treated in a dignified way and most interactions from staff were based around tasks. People and relatives were happy with the staff and when people could mobilise they made choices about their day. Relatives and visitors felt welcomed and were free to visit at any time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People did not receive support in their preferred way. Care needs were not recorded accurately to ensure action was taken. There was an activity coordinator in post however activities were not always taking place. People and relatives knew how to complain but did not feel assured action would be taken. People were involved with reviewing their care.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
Staff did not feel confident concerns they raised would be acted on. Quality monitoring systems were in place but the information

was not always used to bring about improvements. The opinions of people and their relatives were sough however this information was not always acted on. There was a registered manager in post and they understood their responsibilities around registration with us.

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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 visit took place on the 5 July 2016 and was unannounced. The inspection visit was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We also spoke with the local authority that provided us with current monitoring information. We used this to formulate our inspection plan.

The provider had 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.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with six people who used the service, four relatives, four members of care staff, one registered nurse and the activity coordinator. We also spoke to the deputy manager and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for five people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff available and people had to wait for support. One person said, "They are busy. There aren't enough of them". Another person told us, "It could do with more staff, they don't always come straight away". A relative said, "There is not enough staff, definitely not". We spoke with another person who told us they were waiting for staff to support them to get out of bed, they told us, "God knows how long I have been in here. I like to get up just before lunchtime, about 11 at the latest. I keep asking and they keep saying I have to wait my turn. It's not the girls fault they are just too busy and there are clearly not enough of them, this happens most days". We saw this person was supported to get up at 12:55pm. They commented, "It's ridiculous, I'm going straight to have my lunch now". We observed another person pressed the buzzer and requested support from staff. The staff member came and acknowledged the buzzer. They said they would let their colleagues know. We observed it was a further 29 minutes until the staff offered support to this person. Other people told us they were still waiting to get up at lunchtime and at 2:45pm, a staff member confirmed there were still two people waiting for staff to support them to get up for the day.

At lunchtime we observed people had to wait for support with their meals. For example, we saw one member of staff was supporting two people to eat their meals which meant one person was left without support for over 15 minutes. The person was unable to tell us about this experience. A relative said, "The staff struggle to help with the feeding".

We spoke with staff who confirmed there were not enough of them available to support people. One member of staff told us, "We are always short, people leave, they phone in sick or just don't turn up and these shifts are never covered". Another staff member told us a staff member had not turned up on the day of inspection. They told us that a staff member had been called from the residential unit to offer support. They commented, "That doesn't usually happen, it's only as you are here". We had not been informed of this by the registered manger when we discussed staffing levels with them at the beginning of the inspection.

Staff told us of several recent dates when they had worked below the recommended numbers of staff as assessed by the provider. We looked at the rota and this confirmed that when people had telephoned in sick or not come in for their shift, no cover had been put in place. On the day of the inspection the rota did not accurately show who was working that day. We spoke with the registered manger about these shortfalls, they agreed some of the shifts had not been covered and could not provide an explanation for this. They also told us some of the shifts had been covered but the rotas we looked at did not confirm this.

The registered manger told us they used a dependency tool to work out staffing levels. They told us this was based on individual's needs. We looked at records for this. We saw the needs documented on the dependency tool did not always reflect the assessed needs of people. For example, one person had a care plan in place that stated they required 'high levels' of assistance with moving and handling. This included two to one support from staff and the use of specialist equipment. A staff member also told us this person could be 'unpredictable' when moving and handling. We saw on the dependency tool this person's needs around moving and handling had been assessed as low. This meant as the dependency tool did not always reflect an accurate account of people's needs which meant we could not be sure there were enough staff

available.

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

Risk to people were not managed in a safe way. For example, following a safeguarding incident that had occurred it had been agreed that a person should receive one to one support from staff for 24 hours a day. We looked at records for this person where it stated, 'to prevent and protect other residents [person] is observed 24 hours a day by a carer'. During a 45 minute period, we saw that this person was not receiving one to one support and was not observed. The person was in the communal area independently; during this time two other people went into this area and were unsupervised. We saw the person also mobilised to the communal corridor where another person was walking. We brought this to the attention of a staff member. They confirmed this person should be receiving one to one support, but they took no action. We observed the person was without supervision for a further 15 minutes. During this time the person was verbally aggressive so we spoke with the staff member again about this. They told us the agency staff member who was supporting that person had not turned up for their shift. They told us the staff member who was supporting the person was helping to support another person so was unavailable. This meant when risks had been identified recommendations made were not followed by the staff to ensure people were safe.

A person told us they were at risk of falling and did not feel confident. They said, "I am a bit unsteady, I worry when I walk because if I fall there are no staff around. There are buzzers on the walls to call for help but I wouldn't be able to reach this, I would like a pendant around my neck so I can call, that would make me feel safe". We looked at records for this person. We saw the person had a history of falls which included a fall that had resulted in a fracture. The risk assessments for this person gave conflicting information. For example, the 'long term care risk assessment' stated they were at 'medium risk of falls' and the 'mobility needs assessment' stated they were at 'high risk of falls'. Staff we spoke with felt this person was at risk of falling. One member of staff said, "They came in as they had fallen at home, from what I remember. We don't observe them as much as I think we should as they are quite independent, but I think we should be observing them more, they have a walker but they are often unsteady". We spoke with the registered manager who told us this person was not at risk of falling and had not requested a pendant; they advised this was something they could look into.

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

Staff knew how to recognise and report concerns or potential abuse. One member of staff said, "We should watch for anything that may be abuse, it could be anything that we suspect or that we are unsure of". Another staff member told us, "It's protecting the residents; I would report it to one of the nurses, they would report it to the safeguarding people". We saw the provider had a procedure in place to report concerns and when needed we saw that this procedure had been followed.

Medicines were administered to people in a safe way and staff spent time with people ensuring they had taken them. One person said, "They are pretty decent with medicines". We saw staff explain what the medicines were and gained consent from the person before administering. We saw people were offered medicines for pain relief. This is known as, 'as required medicines'. When people received as required medicines we saw there was guidance in place for staff, stating when they could receive this medicines and how much they could have. When people had prescribed creams we saw there was guidance in place stating where this cream should be applied and when. We saw that medicines were stored in a safe place and within the recommended temperatures.

We spoke with staff about the recruitment process. One member of staff said, "I could not start working here until I had all my checks back, it was so they could make sure I was safe to work here". We looked at two staff files and saw pre-employment checks had been completed before staff were able to start working within the home. This demonstrated the provider checked staffs suitability to work within the home.

Good

Is the service effective?

Our findings

At our last inspection we found not all principles of the Mental Capacity Act 2005 were followed. At this inspection we found the provider had made the necessary improvements to comply with the Act.

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 or 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the principles of the Mental Capacity Act 2005 were being followed. We found some of the people living in the home lacked the capacity to make important decisions for themselves. When needed, mental capacity assessments had been completed for people and decisions made in people's best interests. Staff we spoke with demonstrated an understanding of the Act and how to support people. One staff member said, "We should always assume people have capacity to make their own decisions". Another member of staff gave an example of how they gained consent from people. They told us, "We ask people. If they can't tell us we wait for a reaction from them". This demonstrated that staff understood the importance of gaining consent. The provider had considered when people were being restricted unlawfully and had made applications for approval to the local authority as required. DoLS applications for five people had been made for people who lacked capacity and staff were able to identify people who may have restrictions placed upon them. This showed the staff and manager were meeting the requirements of the Act.

Staff received an induction and training that helped them to support people. The registered manger told us the service offered an induction for new staff. They told us staff completed face to face training and had the opportunity to shadow more experienced staff. Staff confirmed this took place. Relatives felt staff had the skills to support people. One relative told us, "I think the staff are skilled in what they are doing". Staff told us the training they received was good. One staff member said, "I feel training is good, we go on refreshers to keep us up to date". Another staff member told us, "I am up to date with my training that is important for the people who live here".

People told us they enjoyed the food and were offered a choice. One person said, "The food is great you get a variety". Another person commented, "In the lounge there is a menu and what you can have". We saw there were cold drinks available in the dining room for people and hot drinks and snacks were offered in the communal areas throughout the day. We saw that when people needed specialist diets such as a soft diet this was provided for them in line with their care plan.

People told us they had access to health professionals. One person said, "The GP will come, if needed". Records confirmed people attended health appointments and when referrals were needed to health professionals these were made by the provider. We saw referrals to speech and language therapists and

dieticians. This demonstrated when a person needed access to health professionals it was provided for them.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a dignified way. One person requested we remove some used gloves from the end of their bed. They said, "The staff have left them there, look at the state of them". In some of the rooms we observed there were crumbs on the floor and grapes, chocolates and chocolate wrappers on the carpet around people's beds. We observed people were left uncovered in their beds with the doors open and people's dignity was not promoted. For example, we observed one person received support from staff, after the staff finished offering support we observed that the person had sleep in their eyes which had not been removed by the staff. The person was unable to tell us about this. We observed that staff had little time to spend with people and conversations were based on tasks that staff needed to complete with people. For example, if people needed support with personal care. One person commented, "They don't have a lot of time to chat".

People were encouraged to be independent. One person said, "I do most things by myself, they just helped with the bits I can't, which I like". Staff gave examples of how they encouraged people to remain independent. One staff member said, "We let people do what they can for themselves, it's good for them to keep up their skills". People and relatives were happy with the staff. One person said, "The girls are nice, they are all nice to me". Another person told us, "Most are very caring". A relative commented, "I think the staff are fine".

When people could mobilise independently they told us they made choices about their day. One person said, "I walk about all day long, and I sit outside if I want for a while". Another person explained they preferred to stay in their room for the majority of the time as it was quieter.

Relatives and visitors told us they could visit anytime and felt welcomed. One relative said, "I do come in everyday". Another relative told us, "I have been made welcome". We saw people's friends and relatives visited throughout the day.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive support in their preferred way. One person told us how they like to have a hot drink in bed when they woke up, they said, "I like to get up early which I can, but I don't have a drink till breakfast, I like a drink when I wake up". Another person told us, "I get up about 6am and have my medicines, I would like to have a cup of tea then but I have to wait until 8am or 9am with my breakfast". This demonstrated people's preferences were not always delivered.

Care needs were not always recorded accurately to ensure the correct action was taken. For example we saw in one person's care plan they had a recommended daily fluid intake they should have to remain hydrated. This was following a report from a dietician. A chart was completed daily for this person stating how many fluids the person had, however this was not totalled up. We checked the totals and found the person had not received the recommended amount as stated in their care plan. We did not see any action had been taken in relation to this. This demonstrated the systems in place were not effective in ensuring people's care needs were met.

We saw there was an activity coordinator in post, however activities were not always taking place. For example we looked at the activity timetable for the day which stated that during the morning a 'daily sparkle and reading discussion' should take place followed by 'eyes down bingo'. We did not see either activity taking place. One person said, "I don't think we have activities today". We observed that boards with photographs were being put up around the home, however people who used the service were not taking part in this. People told us there was not a lot for them to do. One person said, "I sit here and watch telly". Another person told us, "I don't do much at all I just watch the news until breakfast". This meant people were not always supported to take part in activities they enjoyed.

People and relatives knew how to complain. However they were unsure if action would be taken. One person told us, I have got a couple of grievances, for example the staff can't cope". The person went on to say, "It needs to be sorted there was a meeting last week but nothing has happened". Another person told us, "I tell them if I have concerns, I'm not sure they listen as nothing changes". This demonstrated when people raised concerns they did not feel confident they would be acted on. We saw the provider had a complaints policy in place, when formal complaints had been made the provider had responded to them in line with their policy

People told us they were involved with reviewing their care. One person said, "I would think my daughter did all the paperwork for me, I asked her to". Another person told us, "They asked me about me, when I came" A relative told us, "I was involved with the paperwork". Records confirmed where possible people had been involved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found medicine administration records were not countersigned when needed and there was no guidance for staff when people required creams to be applied. We found these concerns had now been actioned by the provider. At this inspection we found some improvements had been made, however we found further improvements were needed. For example, the staff told us they knew how to whistle blow and we saw the provider had a policy in place for this. Whistleblowing is the process by which staff can raise concerns about poor practice. However we received comments from staff that indicated they did not feel assured they would be supported to do this and did not feel action would be taken by the registered manager. Staff gave us examples about how concerns had been raised and no action had been taken. This demonstrated when concerns were raised there was lack of confidence they would be dealt with.

There were systems in place to monitor the quality of the service. However we did not see how this information had been used to bring about changes. For example, monthly individual medicines audits were completed by the provider. On three of the four audits we looked at, we saw concerns had been identified. On two occasions it was documented that medicines were unaccounted for. There was no documentation to show this had been followed up or what action had been taken. We spoke with the deputy manager who told us they had followed this up. They said they had identified that the unaccounted medicines had been destroyed, they did not show us any evidence to support this, or tell us what action they had taken to prevent this from reoccurring. This meant we could not be sure when concerns were identified action was taken to make improvements.

When completing a stock check on as required medicines we found there was no system in place to identify what stock levels for medicines should be. The registered manager told us stock levels should be carried over on the medicines administration records (MAR). Records confirmed this had not been completed .Furthermore we counted the medicines and this did not match the amount that was documented on the MAR as administered. We spoke with the deputy manager about this; during the inspection they looked into this and identified this inaccuracy had occurred prior to February 2016. We looked at medicines audits that had been completed. These audits had not identified this inaccuracy and therefore we could not be sure they were effective.

We saw records from a resident and relatives meeting. It was identified that an action raised was that 'a pictorial menu was available at mealtimes and when people ordered their meals'. The registered manager told us this was now implemented. At mealtimes we did not observe this being used by staff. A person told us, "I don't think I have seen it, they tell me the choices and I pick". We asked a member of staff if this was available and in use, they told us they, "Thought it was". However they looked for it and were unable to find it. They added, "It must be in the residential home as they always use it there". This demonstrated when people and relatives made suggestions to improve the service these were not always actioned by the provider.

There was a registered manager in place. People and staff knew who the registered manager was. One person said, "I have seen the manager, yes". A relative told us, "Yes I know who the manager is, and she asks

is I'm happy with everything". We saw the previous rating was displayed as required in the reception area. The registered manager understood there responsibility around registration with us and notified us of importance events that occurred at the service. This meant we could check the provider had taken appropriate action.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed in a safe way and when risks had been identified recommendations made were not followed to ensure people were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available and people had to wait for support.