Lifestyle Care Management Ltd

Springfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 January 2017. The inspection was unannounced and was the first one since the service has been registered with the Care Quality Commission (CQC), however the service was previously registered with CQC under a different legal entity.

Springfield Care Centre is a care home with nursing for 80 older people with dementia and/or nursing needs. There were 75 people using the service during the inspection.

The service had a registered manager. 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 that there were not enough staff deployed to ensure people were safe and their needs met. People and staff told us and we observed that people could be at risk due to shortage of staff to monitor and provide care according to their care plans and risk assessments. However, we saw that the staff were caring, kind and compassionate when providing personal care and supporting people. Staff respected people's privacy and dignity, and ensured that care and support was delivered in line with the principles of the Mental Capacity Act 2005.

Staff had various training opportunities in areas relevant to their roles and there was a supervision system which ensured that staff had supervision and support. We also noted that the provider undertook various checks when recruiting staff. However, we made a recommendation regarding lack of checks in gaps in employment history.

During the inspection we noted that there was unpleasant smell in some parts of the home and there was a need for general refurbishment. The registered manager was aware of these concerns and had a plan in place to address them. We made a recommendation for the registered manager to follow best practices when making changes to the service premises.

Staff reviewed care plans and we noted that people and/or their relatives were involved in developing and reviewing these. Although the care plans were detailed and people received appropriate care and support, not all people were provided with appropriate, stimulating activities. We recommended that the registered manager looks for best practices of person-centred activities to meet people's individual needs and interests.

The service sought feedback through relatives' and staff meetings, and through survey questionnaires sent to families. There were also various auditing systems for checking medicines, incidents, care plans and health and safety.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this 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 always safe. There were not enough staff deployed to people's needs.

There was an unpleasant smell which made the service premises uncomfortable for people and visitors, and increased the risk of the spread of infections. The registered manager had a plan to replace the carpets.

The service had a staff recruitment system in place but gaps in employment history were not consistently checked for some staff.

Risk assessments had been completed for people and staff knowledge of adult safeguarding including the actions they were expected to take if there was an incidence of abuse.

People's medicines were administered safely.

Is the service effective?

Good

The service was effective. Staff had opportunities to undergo training to improve their knowledge and skills of caring for people.

Staff told us they had regular supervision from the line managers. They told us they felt supported by their managers and colleagues.

Staff and managers understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLs), their responsibilities under this legislation and acted to put this into practice. People's liberty was not unnecessarily restricted and staff supported them to make choices in their lives.

Staff contacted healthcare professionals and specialist services when people had needed this to make sure that appropriate support, advice and treatment was accessed promptly.

The food provided was good and nutritious.

Is the service caring?

Good

The service was caring. People and their relatives told us that staff were caring and they felt well looked after. We saw that the staff treated people in a supportive and respectful way.

Staff knew the people they were caring for and supporting, including their personal preferences, their likes and dislikes.

Is the service responsive?

Good

The service was responsive. Care was planned and provided based on people's needs assessment.

People could choose activities of their interest and the service had two activity coordinators. However, appropriate, stimulating activities were not always available for people who stayed in their bedroom.

There was a complaints policy in place and people were confident that their concerns and complaints could be taken seriously.

Is the service well-led?

Requires Improvement

The service was not always well-led. Relatives told us that although the managers dealt with their complaints, they never saw them on the 'floors'. They told us there was a lack of discipline with some staff.

A range of quality assurance and audit systems were in place for monitoring and improving the quality of the service. Relatives and staff meetings enabled them to share their views and influence the quality of the service.

There was a good management structure in place which ensured the manager was supported by junior and senior managers.

Springfield Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 18 January 2017.

The inspection team consisted of two adult social care inspectors. Before our inspection visit we looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers are required to tell us by law.

During our visit we spoke with six people who used the service and seven relatives. Some people who used the service could not tell us about their experiences due to dementia, so we observed their care using 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 spoke with a visiting healthcare professional, the area manager, registered manager, deputy manager, and eight care workers.

We looked at records relating to different aspects of the service including the menus, staff rotas and quality assurance systems. We reviewed seven people's care records and 10 staff files.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us people were not always safe in the service because of low level of staffing. One person said, "Staff are all right, sometimes they come promptly." A relative told us, "Today I feel [my relative] is safe but not always. They are short of staff. They do not check on [the person using the service] regularly and the person needs monitoring with their [medical and personal care]". Another person told us, "The staffing levels are dreadful in dementia unit. There was a time when there was only one member of staff in the unit one day. The nurse came very late." We also observed that staff were not always available in the lounge where some people spent long time dozing in chairs without supervision.

We looked at the staff rota and noted that there were a maximum of four and minimum of two care staff with a nurse in each unit during the day shift. The registered manager told us that staff were allocated on the basis of people's assessed dependency levels. However, staff told us and we noted in people's personal care and support records that around two thirds of the people using the service needed two staff for support with personal care. For example, one relative told us that staff could not support a person with personal care because the member of staff was on their own and the person using the service needed two staff. We were told that the person was left in a wet pad for many hours. Another relative told us that staff were not always available to check medical equipment in the bedroom as required and to attend to attend person's personal care. They told us that the person using the service would "suffer if the family were not involved". This showed that the service did not have enough staff deployed to ensure people were always safe.

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

We reviewed staff files and noted that most of them were appropriately checked to ensure that they were safe to care for people using the service. We saw that a Disclosure and Barring Service (DBS) check had been undertaken before staff were employed. This was carried out by the DBS to ensure that the staff were safe and were not barred from applying to work with people who required care and support. There was also evidence in staff files that they had completed application forms, attended interviews and provided two written references to show they were suitable to care for and support people. However, we found in three files that the registered manager had not explored gaps in employment history. We recommend that the registered manager follows best practice of staff recruitment to ensure that staff are appropriately vetted and safe to support and care for people.

Staff told us they knew what adult safeguarding meant and the actions they needed to take if they became aware of any incidence of abuse. They told us they would record incidents and report them to their manager. Staff also told us they were aware that they could raise concerns or incidence of abuse with the local authorities, police and the Care Quality Commission (CQC).

Records showed that people's risk assessments had been completed and reviewed. Staff told us and we saw that the risk assessments were updated monthly or when people's needs changed. We saw that the risk assessments were detailed and included risks such as allergies, falls and pressure sores. Records showed

that the risk assessments contained guidance for staff regarding what they should do to ensure the risks to people were managed. However, we noted that there were no risk assessments around some people leaving their bedroom doors open. During the inspection we observed a person using the service entering another person's bedroom without an invitation or asking permission. When we discussed this issue with staff they told us that there was an hourly monitoring plan in place for the person. However, there was no record or chart to confirm that there was a plan to monitor the wellbeing of the person on an hourly basis. We recommend that the registered manager seeks best practice guidance to ensure people and their belongings are appropriately safeguarded from other people who use the service.

Relatives had mixed views about the cleanliness of the service. A relative told us, "The room is clean but it has never been painted in the last five years -maybe it needs painting." Another relative said they visited the service every day and they always found the bedroom was clean. However, a third relative told us, "The cleanliness is awful. It smells [bad]." We noted that there was smell of urine in corridors. We received written information from a visitor stating that "upon entering [the nursing home] and throughout the building there was a very strong of urine...." We also saw that the carpets in some areas of the home were stained and that there was unpleasant smell in the corridors and some common areas. This created uncomfortable conditions for people who lived in the service and the visitors. It also meant that appropriate action was not taken to ensure the service was clean and the risk of spread of infection was controlled. The area manager and the registered manager told us that they were aware of and working on the problem. They said that the provider had decided to replace the carpets which would help solve the problems. We recommend that the registered manager refers to the best practice of assessing and supporting people who are incontinent, and also refers to NHS England and leading dementia charities' advice regarding the use of carpets in care homes for people living with dementia.

We reviewed medicines and medicine administration record sheets (MARS) and noted the nurses administered the medicines and signed the MARS to confirm people received medicines as prescribed. There was a clear medicine policy in place for staff to understand and follow. We spoke with a member of nursing staff who was responsible for management, stock checks and audits of medicines in one unit and they talked us through the processes in place for ordering, reconciling and disposing of medicines. The systems in use helped to prevent accumulation of medicine and reduced the risk of errors happening. We were informed that nursing staff took turns to audit medicines in different units so that errors could be picked up and rectified in time. This was in addition to the monthly medicine audits by the registered manager and deputy manager. We saw samples of these audits. We noted that clinical rooms and refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges. This helped to make sure that the medicines were in good order for use.

Good

Is the service effective?

Our findings

People received effective care from staff who had appropriate knowledge and skills to deliver care and support that they needed. People, relatives and a visitor were able to confirm that staff were competent and knew their roles and responsibilities. One person told us,"[Staff] do a good job. They have the right skills [to support people]." A relative said, "The home is excellent. Staff know how to help [people]." However, another relative told us, "Some of the staff are knowledgeable but I do not feel some of them have dementia training." A visiting health professional told us that the staff acted effectively on the advice they gave and treated people with respect. Feedback we received from another professional showed that the staff were trained and able to meet people's needs.

Staff had training opportunities in a wide variety of areas related to their role. The registered manager told us and records showed that dementia was part of the training programmes staff attended. We discussed a relative's concern that they did "not feel some [staff] have dementia training" to support people with dementia. The registered manager assured us that dementia would be discussed in team meetings and one-to-one supervision in addition to the training staff received. This would help to ensure that staff had an up-to-date knowledge and practice of supporting people with dementia.

We noted that the majority of staff (80 per cent) had completed mandatory training. The registered manager said they were confident the figure would rise from 80 to 90 per cent in the coming few weeks when new staff took up their role or completed their probation period. They had completed and sent an action plan to their head office in relation to training. Training was recorded on a computerised system and the list of training included diet and nutrition, food safety, adult safeguarding, understanding and managing behaviour, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS).

The 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 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 noted that staff and the registered manager knew about the requirements of MCA and DoLS. Staff knew what constituted restraint and knew that a person's deprivation of liberty must be legally authorised, if needed for their own safety. The registered manager told us and records showed that assessments of people's capacity had been completed and where appropriate DoLS obtained for some people.

Records showed all staff had regular supervision. Staff told us they felt they were helped with their own development and understanding of people's needs through regular supervisions. Supervision was arranged in units which meant that a named nurse in a unit carried out supervision with a care member of staff they worked with. Staff told us that this worked well for them and they were able to discuss practice and training issues in their supervision. They told us that they could also receive support from their colleagues.

People and relatives told us that the service provided food that met people's needs. One person said, "The food is good, nutritious and well balanced." Another person said, "The food is fine. They give you the menu and ask you [to choose what you want]." A relative told us that they had no concerns about the food. Care plans showed that people's dietary needs and preferences were taken into account in the provision of meals. Some people were taking pureed diets due to swallowing difficulties. This was following their referral to and assessment and recommendation by a dietitian or a speech and language therapist (SALT). Staff told us that people could receive meals that reflected their cultural or religious preferences. We noted that food items were stored in clearly marked fridges and freezers to show they were not mixed up. There were four weekly rotating menus and the service had two chefs who were supported by assistant chefs. We noted people were supported with their meals and their weights were measured. Staff told us that if they noted significant changes in people's weights, they would refer them to their GP or a dietitian.

A GP came once every week and could be called as required to check people's medical needs. Staff told us and records showed that people were referred to and received medical care from appropriate healthcare professionals such as district nurses, tissue viability nurses and from hospital doctors.

Good

Is the service caring?

Our findings

We observed people were relaxed when staff communicated with and supported them. We saw staff were gentle and showed kindness and compassion during their interactions with people and relatives. One person told us, "Staff are fine. They do care very well." Another person told us that there was a member of staff they were not happy with and complained about to the manager. They said the member of staff was no more working at the service and they were now happy with all staff caring for them. A relative told us, "Staff are very respectful and caring." Another relative told us that they were happy with most of the staff. A third relative said, "The staff are helpful. I was happy to get [my relative back to the service] from a hospital." A complimentary letter sent to the service a day after our visit stated that the relatives of a person who used the service were satisfied and were "grateful [to staff] for the love and care they gave [the person] during the [number of years they were at the service]."

People's care plans identified people's needs ('problems identified'), the support required to meet the needs (goals) and how staff should assist people to meet their needs. Care plans contained information about people's likes, dislikes and how they wanted to be supported. Staff told us they read care plans and knew people's needs. A nurse told us that discussed any changes to the care plans with staff so that they had the latest information to be able to meet their needs. We noted the care plans were updated monthly and there was evidence in the files that people or their representatives were involved. One person told us that they were "involved in my care plan" and that it was "in the office". A relative told us they were involved in the review of the care plans. A comment made by relatives in one of the care plans stated that they "could not praise enough the work done at the nursing [home] and the excellent care [a person] receives from the whole team".

The service managed end of life care well, and people's preferences about this were recorded in their files. We noted some people had completed 'Do Not Attempt Resuscitation' forms in their records and these were appropriately completed in consultation with the person or their representatives.

Two relatives told us that personal items such as clothing went missing sometimes but were always returned. We noted that a key working system was in operation. The role of the key worker was to have special interest in a person's care including their possessions and review of their care plans. During our observation we noted that a member of staff spending time with five people in a lounge was not actively engaged with or paid attention to some of them. We discussed this with the registered manager who said that she would investigate this and would ensure that it was discussed at team meetings and staff supervision. Overall, however, we observed that staff understood the importance of person-centred care. A member of staff told us, "We know each person's support needs are different. We treat people as an individual."

People and relatives told us they wanted the bedroom doors left open. One person said, "I like the door to be left open." A relative said it was important the bedroom door remained open at all times. However, we noted that staff were aware of why and how they needed to ensure people's privacy and dignity. We saw that staff knocked on the doors before entering bedrooms. A member of staff also described how they

ensured people's privacy when providing personal care. They told us depending on the risk assessment and wishes of the person they would shut the door and cover the person when supporting them with personal care.

Relatives told us that they were made "very welcome" when they visited and that they could come at any time of that suited. A relative told us that they or their family members took turns to visit every day and staff always made them welcome. Another relative said there had been no issues about them visiting daily and staying as long as they wished.

Good

Is the service responsive?

Our findings

Before people came to live at the service the registered manager visited them to carry out a comprehensive assessment of their care needs. People or their relatives also visited the service to see if it was suitable to their needs. This would help the service and people or their relatives to make informed decisions whether or not it would meet their needs. The pre-admission assessment was also an opportunity for the service to identify people's needs and provide appropriate service including any special equipment or staff with suitable training and skills to meet people's needs.

Each person had a care plan based on their on their assessed needs. We observed that some spent time in the lounges whilst others stayed in bedrooms either in beds or sitting on the chairs. A person told us, "They are accommodating. I do go out a lot. I do some [activities]." We saw people in the lounge watching television or listening to music. However, we saw most people were in their bedroom during the visit.

The service had two full-time activity coordinators. We observed an activity session where the coordinator performed an activity in front of people in the middle of the lounge. It was not clear from the observation if people liked this or not, or if they liked the music being played. Some appeared to respond to both the performance and the music, for example, clapping or moving to it. Others did not appear affected or make much response. However, we noted that the activities coordinator tried to motivate and engage people by, for example, moving closer to them or through eye contact. People told us they liked the activity.

A programme of activities for each day of the week was displayed on the walls at the service. The list of activities included discussion groups, entertainment, film, TV, tea, coffee event, pampering, exercise, bingo, residents' shop, newspapers, table top games, and knitting. Staff told us that people could also choose activities not included in the programme. During the visit we saw a hairdresser who, staff informed us, came every week.

During our tour of the premises and observation of people, we did not see activities being provided to people who remained in their bed. Whilst some of these people had visitors during the day, there were others who did not have relatives or friends coming every day. We recommend that the registered manager looks for best practices of person-centred activities to meet all people's individual needs and interests.

The service had a complaints procedure that was displayed in the home. We looked at the records of complaints that had been received, investigated and resolved since February 2016. We saw that 13 complaints were recorded and investigated. We noted that the complaint records were well organised and complaints were addressed promptly as required by the service's own procedures. A person who used the service told us that they knew how to complain and in fact they had made a complaint to the registered manager. They said they were satisfied with the way their complaint was managed and resolved. A relative also told us they had made a complaint and were happy with its investigation and outcome.

Requires Improvement

Is the service well-led?

Our findings

We received a written concern stating that a member of staff could not tell a visitor if or when the registered manager would be in the office to help them with their queries. A relative told us that that they were satisfied with how the registered manager dealt with their complaint, but they were not happy with the overall management because "I never see managers up on the floor". Another relative told us that whilst "staff are reasonably ...skilled and trained, there is a lack of discipline. Some [care staff] shout at the nurses. Carers do what they like".

The registered manager told us that there were various ways they took responsibility to check the quality in the home. They said they walked about daily to observe the safety and provision of care. They picked four rooms daily to have a closer inspection of people's rooms to ensure their safety. In addition, the registered manager told us nurses each picked a 'service user of the day' where each nurse looked at one person's notes in more detail and brought it to the daily 'flash meeting' for discussion. Flash meetings (attended by nurses and heads of departments) were aimed at staff talking about care issues relevant to the day, any urgent issues, current concerns or any issues from relatives or others. It was also for sharing information and learning from each other, for example, about any incidents, safeguarding issues, pressure sores, complaints and medicines issues. There was also a look at the 'Staff of the day' task, where the registered manager checked an individual staff member's file to ensure all key documents were in place.

The registered manager explained how feedback about the quality of the service was sought. This included survey questionnaires which were to families. We were informed that survey questionnaires had been sent to but not yet received from families. The registered manager told us that similar feedback was also undertaken by the head office. The registered manager told us they did not know the outcome of the survey undertaken by the head office and have no plan of action based on the feedback. This showed that the registered manager did not have an effective quality assurance system in place.

The registered manager informed us that relatives' meetings took place two to three times a year. This was confirmed by relatives who told us that they had attended relatives' meetings. We also saw copies of some of the relatives' meetings. The registered manager and staff told us, and the minutes confirmed that staff meetings took place. Both the relatives' and staff meetings helped the service to seek their views about the quality of the service. For example, a relative told us that through the meetings they were able to discuss their concerns about some personal items going missing and the strong odour in the home. They told us the registered manager reassured them to address their concerns.

Health and safety audits and internal checks were well established and included fire safety, water temperature checks and service maintenance checks, nutrition and people's weights, care planning, complaints and safeguarding. Every month the registered manager completed a 'clinical governance form' on staffing, training, risk management, clinical issues and information management. A compliance officer from the provider organisation's head office came once every month to undertake an audit of various aspects of the service including care records and management of the service. The regional director also came to provide support and supervision to the registered manager. The regional director and the

registered manager promptly responded to and dealt with enquiries we forwarded to the service. Written comments we received showed that the registered manager worked cooperatively with commissioners from the local authority.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not always deploy enough staff to ensure people were safe and their needs were met.