Fairfield Residential Limited

Springfield House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 8 and 9 March 2016. Springfield House was last inspected in January 2014 when it was found to be meeting all of the standards reviewed.

Springfield House is registered to provide residential services for a maximum of four adults who have a learning disability. Some people may also have a mental or physical disability. At the time of our inspection four people were using the service. People were using the service in different ways depending on need and other personal circumstances. Some people visited daily and then stayed for 1 or 2 nights each week, others stayed in the service on a residential basis but spent time away from the service with immediate family or other relatives.

There was a registered manager in place at the 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.

Due to the unique communication styles of the people living at Springfield House we were not able to speak with everyone using the service. We made observations and spoke with people's relatives, the home's staff and other visiting healthcare professionals involved with the service to understand their experience of the service.

We saw the measures that the service had put in place to protect people and keep them safe from harm. Relatives told us that they thought that the service was safe. The service had a safe system in place for the recruitment of staff. Staff had received training in safeguarding vulnerable adults and could clearly describe the action they would take if they suspected any abuse had taken place.

People's medicines were well managed by the service. Support staff administering medicines had been trained, assessed for competence and told us they felt confident in doing so. Medicines were safely administered with clear guidelines in place for any 'as required' medication that had been prescribed.

The home undertook risk assessments for all aspects of people's care and support. People's support plans and risk assessments contained personalised information about an individual's needs and provided guidance for staff as to the support people needed and the routines they followed. Equipment used to support people was well maintained and regular health and safety checks of the premises were made.

If people's needs changed a system was in place to liaise with the person, their family and other professionals to update care plans and risk assessments. People's health and medical needs were met by having access to GP's and health professionals on a regular basis.

The home was clean and tidy throughout and staff used personal protective equipment (PPE) such as gloves

and aprons when necessary. We identified a small infection control concern around limited hand washing facilities when people using the upstairs bathroom did so independently and brought this to the registered manager's attention.

An induction programme was in place for new staff to complete required mandatory training courses and shadow existing staff. Staff training was available and staff confirmed that they had completed training courses relevant to their role. The training matrix was up to date and reflected all mandatory elements plus any additional training undertaken by staff.

We found that the service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be unable to make their own decisions. People's support was assessed and agreed with the person, their families and the respective commissioning team prior to a referral being made to Springfield House. Support workers had a good working knowledge of the MCA and how it affected the people using the service. The home was compliant with both the MCA and DoLS.

People were supported to eat a healthy diet. They were involved in choosing meals, shopping for food and meal preparation. Meals were cooked from scratch using natural ingredients as opposed to giving people ready meal options.

Relatives we spoke with and other healthcare professionals involved with the service said that the support staff were caring. Staff we spoke with knew people well as individuals and understood their routines. We observed staff interacting with people with warmth and humour but were firm in their approach when they needed to be. Each staff member adopted a consistent approach with people in the service so that boundaries were not crossed and routines were upheld.

During our inspection we could see that staff members respected the privacy and dignity of people using the service. Staff we spoke with could provide examples of how they did this. There was a relaxed and friendly atmosphere at the home. Staff acted with the person's best interests in mind.

Staff promoted people's independence by giving them choices. People were encouraged to take part in domestic tasks so that Springfield House felt like their home. The service acknowledged different cultures and beliefs. One person using the service was of the Islamic faith and practiced muslim traditions in their own home. We saw that family were happy for the person to participate in other traditions whilst at Springfield House and staff supported them in making informed choices about their participation.

People's care plans contained information about their likes, dislikes and personalities, and were very much person-centred. They contained details about how people liked to communicate and be supported in all aspects of their care. Technology to aid communication between people and the staff had been fully explored and adopted by those who wanted to use it. Care plans were up to date and reviewed regularly by people's keyworkers and the registered manager. People received support as it was described in their support plans.

There were enough staff on duty to meet people's support needs and to provide activities for them. People's access to activities was very good; we saw that they were supported to get out and about in the community and to pursue hobbies they enjoyed. Families were kept up to date of all activities undertaken by way of a communication book and photographs emailed to them.

Staff told us that they felt supported by the registered manager. Formal supervisions took place and staff we

spoke with valued these sessions. Regular team meetings were also held and staff were able to raise any issues or concerns at these meetings.

A system was in place for responding to complaints. We were told by relatives and staff that the registered manager was approachable and would listen to their concerns. We saw evidence of how the manager pro actively dealt with concerns or issues raised by family members and how they kept people informed of actions taken by the service.

All aspects that could influence people's care was reviewed and evaluated monthly, including accidents and incidents, individuals' health and well-being, and health and safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Relatives told us they felt that people at the home were safe and we observed that people seemed happy and relaxed in the company of staff.

All aspects of people's care and support had been risk assessed. Accidents and incidents were well documented and any physical interventions were recorded appropriately.

Recruitment processes were robust and all appropriate checks had been undertaken.

Medicines were managed and administered safely.

Safety procedures were in place at the home and equipment had been checked to make sure it was safe.

Is the service effective?

Good

Staff told us they were trained appropriately to care for and support people who used the service.

People were supported to eat a healthy and varied diet, whilst being allowed fast food as a treat.

The service was meeting the legal requirements relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staff participated in best interest meetings, organised on behalf of those who did not have mental capacity.

People were supported to maintain good health and had access to a range of healthcare service.

Bedroom environments were personalised for individuals and were clean and tidy.

Is the service caring?

Good

Relatives said staff were caring. People were happy living at the home.

Staff were patient, treated the people with dignity and respected their choices.

Staff knew people well as individuals and could describe their likes, dislikes and personalities.

Staff described how they tried to promote people's independence by encouraging them to do as much as they could themselves.

Is the service responsive?

Good

People's support plans were reviewed regularly. Any changes in support needs were documented accordingly.

There was good use of assistive technology to help with communication between people and staff.

The home had supported a person to undergo a medical procedure and had gone to great lengths to ensure this was a success.

People were supported to take part in a wide range of activities based upon their personal preferences.

Relatives were aware of how to complain although those we spoke with had never needed to.

Is the service well-led?

Good

Relatives and staff spoke highly of the registered manager. The registered manager was pro-active in responding to any issues raised.

A staff award scheme had recently been introduced. Staff felt involved in the service and listened to.

The system of audit and monitoring involved staff from all levels of the organisation. Any recommendations made had been acted upon.

People, relatives and staff had regular opportunities to suggest improvements to the service.

Springfield House

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 8 and 9 March 2016 and was unannounced. The inspection team consisted of one inspector.

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

We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. No concerns were raised about the service provided by Springfield House. We liaised with other professionals involved with the service at the time of our inspection and received complimentary feedback about management and staff.

With their permission we spoke with one person who used the service, communicated with two others, spoke with three relatives of people who used the service, the registered manager, the service manager and four care staff. We observed the way people were supported in communal areas. Due to the limited verbal communication of some of the people living at the service, and the nature of their learning disability, the people we spoke with responded to the questions with brief answers or with a "yes" or "no." We were able to see from people's body language and actions that they were relaxed and happy in the service.

We looked at the care files and medication administration records (MAR) for three people who used the service, daily record notes and communication book entries made by staff. We also looked at a range of records relating to how the service was managed including four staff personnel records, staff recruitment and training records, compliments and complaints, accident and incident logs, quality assurance tools,

audit records and company policies and procedures.

Good

Is the service safe?

Our findings

Springfield House's statement of purpose outlines that the service provides a safe, supportive and calm 'home from home' environment for adults aged 18 to 65 on the autistic spectrum and/or with presentations of learning disability.

During our inspection we saw the steps taken by the registered manager and staff to ensure the safety of people using the service and the mechanisms in place to help achieve this. Relatives we spoke with had confidence in the service. When asked if they felt people were safe relatives told us, "Yes I do. Yes I do feel [person] is safe," "Absolutely, yes," and "staff are very on the ball with safety."

People's care files contained risk assessments for various aspects of their care and support. Examples of these included moving and handling, bathing and showering, travelling, neglect and abuse, and medicines. People were supported to take risks if they could be mitigated or the benefits were justifiable. This showed that the service was mindful of the risks of providing care and treatment but also supported people to take risks if they could be managed appropriately and benefitted the people.

Staff showed that they understood people's risks and we saw that people's health and wellbeing risks were assessed, monitored and reviewed. We saw that people were supported in accordance with their risk management plans. Accidents and incidents were well documented and any physical interventions recorded appropriately, with good use of accompanying body maps to indicate if any injuries were sustained by the individual.

We looked at four recruitment files and saw that the process was fair and robust and that personnel files were in good order. The correct paperwork was on file in relation to the recruitment process and recruitment records for staff included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for those employed by the service. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

We looked at rotas and saw that staffing was adequate to meet the varying needs of the people who used the service. There were enough staff on shift to ensure that people were able to undertake activities, either individually or together. We observed on the day of the inspection that there were sufficient staff to meet the needs of the people who used the service. One person liked to have a drive out every day therefore there was always a member of staff on duty who was able to drive in order to accommodate this activity. This activity was documented in their support plan.

We looked at systems in place with regards to the administration of medication. Staff had received training on how to support people to manage their medicines. We saw that medicines were managed safely. Systems were in place that ensured medicines were ordered, stored, administered and recorded to protect people from the risks associated with them. For example epilepsy tablets were correctly stored in their

original boxes. It had been discussed at a staff meeting that these could not be included in blister packed medication as they lost their strength and would therefore be less effective and minutes of the meeting reflected this.

There was a protocol in place for PRN medicines (medicines to be taken as required). Staff who had been trained and assessed as competent administered medicines. During the inspection there was an occasion when an individual presented with challenging behaviour. Distraction techniques from staff did not work and as the person was becoming more distressed staff identified that PRN medication was necessary for the individual. This was administered safely and discreetly, away from other people in the service and the individual was compliant when offered the medication.

People were kept safe from financial abuse with the processes in place to record, monitor and audit all monies spent by people using the service. The service was, "very good with finances," we were told by a relative we spoke with. Each month relatives received a print out of what had been spent along with corresponding receipts. This was checked and signed by the relative and a copy returned to the service for audit purposes.

The home's fire policy was to evacuate the building and we saw that this was practised on a monthly basis. Names of individuals and staff involved in the evacuation were noted after each evacuation. People were supported to leave the building if required, as identified within their Personal Emergency Evacuation Plans (PEEPs). Other health and safety checks on the building were up to date, including portable fire fighting equipment, emergency lights and smoke alarms.

The home was clean and tidy and cleaning materials were appropriately stored in a locked cupboard, accessible only by staff. Relatives we spoke with commented on the cleanliness of the home and individual bedrooms. We noted that the upstairs bathroom lacked toilet paper, soap and hand towels and the reasons for this were explained to us. When people came upstairs to use the bathroom we saw that staff supplied the person with toilet paper then allowed privacy and waited outside. The person was later prompted to wash and dry their hands using soap and a hand towel supplied by staff. This was then replaced in a cupboard on the landing.

During our inspection we saw that a person using the service spent time in their bedroom upstairs, as was their choice. The person visited the bathroom independently but each time was not able to wash their hands as staff were not around to supply the soap and towel. We made the registered manager aware of this and they assured us that measures would be taken to find a solution.

Good

Is the service effective?

Our findings

People's relatives and other healthcare professionals involved with Springfield House were very complimentary about the service and the calibre of staff supporting people using the service. One relative told us, "[We're] very pleased with the way it's gone so far", whilst another commented, "Great improvements [on a previous service]." A relative had provided feedback to the service regarding the difference staff had made for an individual. "[They're] incredibly calm and relaxed; [Person's name] is a credit to you all," and described the staff approach as "professional" and "excellent."

Relatives were kept informed via a communication book. Any activities that the person had enjoyed, or trips they had been on were logged in the communication book. It also contained details of any incidents that might have occurred and informed relatives how these had been dealt with. The communication book informed relatives how people spent their time at Springfield House and the progress they had made. One relative told us the communication book was sent to them when their relative spent time at home with family. "It's useful [the communication book]. I sign it and send it back."

We found the provider followed a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home. This included carrying out a Disclosure and Barring Service (DBS) check and obtaining appropriate references.

We looked at four staff files and saw evidence of a thorough induction programme. The files contained individual certificates for on-going training undertaken and all staff had completed the safeguarding of both adults and children. A colour-coded training matrix indicated any refresher training required by individual members of staff and the manager was able to effectively monitor and manage aspects of training that staff had to complete.

We saw that staff new to the service were allocated the Care Certificate to complete as part of their induction. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. It is based on 15 standards, all of which individuals need to complete in full before they can be awarded their certificate. Staff meetings were held regularly and staff were supervised on an on-going basis.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS) to ensure the rights of people who are unable to make important decisions about their health or wellbeing are protected. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

The Provider Information Record (PIR) submitted to CQC indicated the service had submitted the DoLS applications for all the people who lived at the home. At the time of our inspection the registered manager had received authorisation from the supervisory body, the local authority, for two of the four applications

made.

Staff had received training in the MCA and followed the basic principle that people had capacity unless they had been assessed as not having it. The registered manager had a good understanding of the Mental Capacity Act and was aware of their responsibilities.

We saw some good examples of how the service was following the principles of the MCA . One individual was waiting for an operation. Staff at the home had played a pivotal role in working with other health professionals to move this process on at the right speed, having attended best interest meetings with the individual and their close relative. The operation was imminent at the time of the inspection and we were able to see what the service had put in place to try and ensure the operation was a success for the individual concerned.

We saw the safe systems of working in the kitchen and that the home had achieved the maximum score of 5 in the Food Hygiene Rating scheme, operated by the local authority. Menus were open to change based on people's preferences. For example the soup listed on a menu distributed by the company was potato and watercress. Staff recognised that this would be wasteful as people preferred tomato soup, so tomato soup was ordered instead. The cooking of meals was done predominantly by staff. A member of staff told us that they shopped with a person for Halal meat. This was widely available from larger supermarkets in the area. This showed us that the service acknowledged and catered for different cultures and faiths.

There was a booklet of visual recipes kept in the kitchen and we saw posters in the kitchen displaying the benefits of eating healthily. Families we spoke with all agreed that the service were keen on promoting healthy eating. "[They] encouraged [person] to eat more vegetables which was amazing," one relative told us. Another person we spoke with praised the service as their relative had their weight under control, was now eating sensibly and had slimmed down. This was a "massive improvement" to their physical wellbeing they told us.

Another person we spoke with considered that staff knew what their relative liked to eat and told us that staff attempted to promote healthy options during mealtimes. We saw this in practice on the day of inspection as chicken goujons were on the menu. A member of staff prepared fresh chicken and made a home-made batter to coat the strips of chicken. This meant that people using the service were receiving home cooked food as opposed to the less healthy ready meal option.

We saw that people in the service enjoyed eating fast food. One person communicated to us that they liked eating at KFC. Another person told us that they liked to eat a burger at McDonalds. People were taken out for fast food as a treat, when out on a day trip or when accessing the community.

People were supported to maintain good health and had access to a range of healthcare services and support. Care records showed that people received visits from the GP and had access to the services of a dentist, optician or chiropodist, if required. The families of people who used the service told us their health care needs were well met and that the home worked with other healthcare professionals. One person using the service was due to have an operation and we saw that numerous relevant professionals had been contacted and involved in the process.

Communal areas were decorated in neutral tones and were clean and tidy. The decoration and furniture in bedrooms reflected the personal requirements and taste of the individual. One room was pleasant and colourful with pictures and certificates on the wall. We saw a mirror that the person liked to use and a weekly routine was displayed on the wall.

Another room was minimal in décor with little furniture, had a locked cupboard and there were no curtains up at the windows. Staff had recognised that previously the environment had contributed to the person displaying behaviours that challenged. The member of staff showed us how curtains were hung up on the nights the person stayed at the service, using velcro tabs that were on both the curtains and the window board. These were then taken down again in the morning and stored in the locked cupboard.

By making the bedroom environment personalised for the individual the service had succeeded in reducing the challenging behaviours. We saw the individual using the bedroom at various times of the day, smiling and chatting pleasantly with staff, so this showed us they were comfortable and relaxed within their bedroom environment.

The Fairfield Austic Group, to which the service belonged, had been presented with an Enabling Environments Award. This was displayed in the foyer and was valid until November 2016. The award is a mark of quality that shows a service has met ten critical standards and is an enabling environment. It is awarded firstly to recognise services conducting best practice in promoting mental well-being, and secondly as a quality improvement mechanism to support ongoing development of the environment.

Good

Is the service caring?

Our findings

Everyone we spoke with agreed that staff were caring in their approach. People were very complimentary about the kindness of the staff at Springfield House and the positive attitudes displayed by all staff. A relative told us that, "[person's name] has a very good key worker." and stressed how caring they were. They told us that their relative was very settled and happy at the home. Other relatives described staff as, "Very polite; very helpful" and also told us,"They go out of their way for [person's name] and are genuinely concerned for [their] welfare." A family told us how happy their relative was with the service, "[Person's name] is very happy coming home but [is also] very happy going back to the home. It's a great comfort to us."

One person in the service was due to have an operation. A relative explained to us how the manager had affected the process, in the best interests of the person. The manager had insisted during meetings with healthcare professionals that things were slowed down and made more organised so that daily routines for the person could be altered and done at a pace right for the person. An initial date of early February for the operation was changed to 10 March so that the individual could be introduced to the hospital setting and adapt to what would happen on the day. This highlighted the caring nature of all staff at Springfield House and showed us that they always put the person first.

Staff were passionate, very enthusiastic and dedicated to their work. "We are here to make their lives better," a member of staff told us. We found the staff team were all very co-operative during the inspection. We observed staff to be well-motivated and they interacted well with the people who used the service, consulting with them about all aspects of their daily life. One person came out of their bedroom and held out their hand to the member of staff then touched the member of staff's hand. The member of staff recognised the action. "It means help," they told us and went off to help the individual.

Staff understood the importance of involving individuals in decisions about their lives and encouraged them to make their own choices. We saw people involved in a residents' meeting choosing the food they wanted to buy on the next shopping trip and places they preferred to visit. Staff were patient during the informal meeting and explained to people using the service what they needed to do. "You show me what you like and don't like," a member of staff said and gave people pictures of individual food items to choose from. For example, one person indicated that they did not like to eat carrots and that they wanted to visit the farm as an activity.

We saw each person had a communication support plan summary displayed on a notice board in the dining room. These detailed their own specific ways of communicating and how staff should support them with this. These were due for review once the company appointed a Speech and Language Therapist, the manager told us. One person using the service pointed to symbols on a notice board in the dining area. A member of staff recognised the person was requesting to go to the beach on the train and to have a KFC meal. The staff member took time to listen and responded by explaining that the weather was not that good. "If it gets warmer, [person's name], you might be able to go to the beach." Later that day, we saw that staff took the person plus one other on a trip to Southport, using the home's minibus.

We saw that people's privacy and dignity were respected at all times. Staff asked people whether they required assistance and offered help in a sensitive way. People who used the service could access private space if they wished to, in their bedrooms or within other areas of the home.

We saw discreet instructions on the wall in the bathroom on how to bathe. This showed people the order of the bathing routine, accompanied by pictures. A member of staff we spoke with told us that everybody was supervised in the bathroom but all were encouraged to wash independently. They told us how they prompted people to wash areas of the body by miming what and how to wash. Staff told us that people using the service were also prompted to wash up their own plates and cutlery and do their own laundry. This meant that people were encouraged to maintain life skills and be more independent.

We spoke with a member of staff on the first day of the inspection. They were aware of their role and responsibilities and were able to describe the needs of each individual who used the service. They demonstrated knowledge of dignity and privacy issues and gave examples of how they respected people's rights and wishes.

Throughout both days we spent time observing people in the lounge and dining areas. We saw that people were respected by staff and treated with kindness. We observed staff treating people affectionately and heard staff speaking in a friendly manner. They chose words and used signs and gestures that people understood, and took time to listen and respond to them. Staff displayed respect and admiration for people using the service and we saw that trusting relationships had formed.

One person using the service was seen repositioning the bathroom door and light pull each time the communal bathroom was used. Staff recognised these behaviours and the fact that they were not causing harm to anyone. To interrupt these behaviours would cause anxiety and distress for the individual we were told, so staff allowed them to carry out the routine, whilst supervising from a distance.

We saw a calendar on the wall of a bedroom showing the correct month. Each month displayed a different photograph of the individual, either doing an activity or out on a trip with others. Staff had helped the person to make the calendar on line at Christmas time and was a very personalised item that the person could refer to. This highlighted to us the caring nature of the staff and the respect they had for people using the service.

Good

Is the service responsive?

Our findings

We looked at the support plans of people who were using the service and reviewed whether the care plans were written in a person-centred way. Person-centred care indicates care is specific to the individual concerned. The provider used person-centred plans and good practice tools to support and involve people to make decisions and to help people set their own goals and objectives.

The care plans were centred on the person as an individual. We saw that people's preferences and views were reflected, such as what activities they preferred to do, the name they preferred to be called and personal care preferences. We spoke to staff who were able to confirm their preferences. Staff knew the people they were supporting very well. Staff told us that one person liked to go out on a daily basis and see either trains, planes at the airport or watch buses. They recognised how the person displayed excitement through their body language and told us that "history and experience" played a part in identifying activities people liked to take part in. This meant that people were being supported by staff who knew them well and had a good understanding of their care and support needs.

We saw good use of assistive technology by the provider and people using the service. Two individuals had Ipads and specific software on these was tailored to their needs. For example, one person was proficient in using the Ipad and was able to set their own personal timeline. This included time dedicated to brushing teeth, watching videos, being on the laptop and going swimming. Staff were also able to input into this if it was needed. We saw how specific the timeline could be and how the individual was able to communicate his wishes to staff using the application on the Ipad.

People's support plans contained documentation that would be expected for a service supporting people with autism and learning disabilities. For example, support plans contained a placement care plan; risk assessments; a pen picture; a behaviour management plan; a health plan; a hospital book; a personal emergency evacuation plan; an autism specific assessment and a My Traffic Light document.

With reference to the pending medical treatment for one of the people using the service, we were able to see what lengths the service had gone to to ensure this was a success for the individual concerned. The registered manager had played a proactive role in meetings, and we could see that they had acted in the best interests of the person. If the manager had not been available then support staff had attended on behalf of the manager.

We saw that it was the manager that had insisted that the operation be delayed so that the person could be introduced slowly to the changes in routine and what would happen on the day. During every stage staff took time to explain to the individual what was happening and why. Staff had carried out "practice" sessions with a face mask, simulating what would happen in hospital and acclimatising the person to the new experiences.

We saw that the individual had been allowed to make choices. They had not wanted an ECG to take place during the earlier pre-operation appointment and had displayed signs of distress with the procedure. Health

professionals deemed it safe and appropriate not to carry this out and staff had been allowed to take the person home.

The day before the operation was our second day of inspection. Staff supporting the person undertook a "dry run", breaking the person's usual morning routine by taking them hospital. We were told that the person had been introduced to a wheelchair and had been pushed by staff in it, as it was expected that this would be needed on the day. Other professionals liaised with the home and the hospital offered a side room for the person to recuperate in to minimise any distress that might occur on the day.

At the time of our inspection the operation had not yet happened although we could see the mechanisms that had been put in place to ensure a positive result for the individual. Staff we spoke with were proud of what they had achieved as the person had been involved and informed in the planned care and support as much as possible and had been allowed to make choices.

Immediately following the operation, the manager devised and circulated a chronological report for family, staff and all professionals involved. A copy of the report was sent to the inspector. It summarised meetings that had taken place, noted people involved and what had been agreed at those meetings. The report was useful as it detailed events leading up to the operation and also diarised the rest of the person's day following discharge from hospital and arrival back at the home. It reflected the success of the operation. A relative responded with an email, "I would like to formally say thank you to everyone who made this such a success. I know that it took a lot of organisation – [person's name's] brother and sisters and I are delighted with the results."

We asked family members if people were offered choices with regards to activities and they answered, "Yes I do think [person] has choices." Another family member acknowledged that their relative was happy going on a short drive out on a daily basis. They told us, "It's a quiet life but it's what [person's name] needs."

Activities were varied and tailored around individuals. For example, two people liked walking and we saw lots of photographs of them walking in the countryside and on a short break that they had gone on together. People also enjoyed bowling, indoor games and trips to the cinema, Tatton Park and Chester Zoo.

One person had signed up at a new gym whilst undertaking a college course. Staff recognised after a short period of time the individual was not motivated when attending the new gym. Their actions and body language, especially when travelling past the gym they used to attend, indicated that they preferred the original gym. The person was helped to enrol at their preferred gym and was attending once a week.

The service manager told us about the farm project run by Fairfield Residential group. People using the Springfield House service were able to get involved in learning, gaining and developing new skills and working with animals. We were told the farm was a very important resource to the group and was being constantly developed.

Relatives we spoke with praised the service for keeping them informed and involved if this was their choice. One relative told us they received photographs of outings their relation had been on via email as this was their choice . They told us the manager had sent photos of their relative at the sea life centre, at the library and doing puzzles in the home. We saw an email on a file from members of the person's family asking for the manager's advice about any puzzles or board games their relative liked to participate in. This showed us that family members trusted the service and held the service in high regard.

Relatives we spoke with felt the service was confidential. They were assured that staff were discreet and

people's information was stored securely. They were aware of the home's complaints policy but told us they had never needed to complain. One relative we spoke with told us they would never complain. "I would just email [registered manager]. It would be sorted." Another response from a recent independent survey was, "No complaints, many compliments.[Person] seems very happy."

Good

Is the service well-led?

Our findings

Relatives and staff we spoke with spoke highly of the registered manager and described them as "open" and "contactable". Relatives felt involved and fully informed and told us, "What they are good at doing is keeping you up to date" and "They are always ready to accept my suggestions."

We saw leadership in the home was very good. The registered manager had the required qualifications and experience and was competent to run the home.

The home had an open and transparent culture, with clear values and vision for the future. Staff shared this commitment and vision and were supported through training and clear leadership from the registered manager to provide care and support for the people who used the service. The service worked in partnership with key organisations, including specialist health and social care professionals.

The service had recently introduced a reward scheme for staff in the form of Team Member of the Month. The registered manager told us this was done to promote teamwork as staff members could show their appreciation for colleagues by nominating them. A member of staff had recently been presented with the award and a certificate was displayed in the hall of the home.

The registered manager understood the responsibilities of their registration with us. They reported significant events to us, such as potential safeguarding incidents and safety incidents, in accordance with the requirements of their registration. The registered manager told us that they had submitted Deprivation of Liberty Safeguard applications for all four people using the service to the supervising authority in 2015. Authorisation for two of these had been received two weeks prior to the inspection taking place. The Care Quality Commission (CQC) had not been notified of these authorisations and the registered manager admitted this was an oversight on their part and assured us this would be done immediately. Before the end of the inspection CQC had received the correct notifications in relation to the approved DoLS authorisations.

When we spoke with the registered manager they had a clear understanding of the key principles of person centred care and best practice when working with adults with learning disabilities and associated health care needs. They demonstrated to us a clear vision of the role and purpose of the organisation based on the organisational vision and values.

Regular staff meetings took place and staff told us they felt involved in the running of the home and their ideas to improve the service were encouraged. Team meetings updated staff on practical issues, such as people's care needs and training, but were also a forum for offering support. The meetings provided an opportunity for staff to reflect on their practice and share ideas. Regular supervisions were undertaken by the registered manager with staff, who told us they found these sessions beneficial and good for personal development. Staff told us they felt supported and worked well both individually and as part of a team. "There's always someone at the end of the phone," a member of staff told us.

Staff said that they would be very comfortable in raising a complaint or concern on behalf of people who

used the service if they needed to. They said that they would raise this with the registered manager or the senior managers as they were "very hands on" and "approachable".
Relatives said that they were kept fully informed of any changes and felt that they could approach staff or the registered manager at any time. They said they knew that if they aired any problems they would be listened to and the problem would be dealt with.

The service had consulted with relatives of people using the service in January 2016, asking for feedback about the service. One family member had raised a concern regarding the application of sun cream. They had requested that staff should support a person more with this when the weather warranted it. We noted that the registered manager was pro active in responding to issues raised. We saw a copy of a letter, dated February 2016, sent to the relative in response to the concern. The registered manager acknowledged the request, suggested a solution that caused least distress to the individual and was acceptable to all.

Professionals we spoke with during or contacted after the inspection identified that the care provided at Springfield House was excellent and that people's individual needs were identified and met. They told us that they had no concerns and were complimentary about the care and support people received. A health professional we spoke with during the inspection told us that working with the home in conjunction with an individual's planned admission to hospital had been a "positive experience". The home had been fully co-operative and had accepted all recommendations made, they told us.

We saw records which told us that audits were conducted on a regular basis and by all levels of staff including the registered manager, senior support staff and the service manager of the company. All formally recorded their findings, with action plans developed to make improvements in response to any issues identified. We noted that an audit of finances in January 2016 had recommended that the process could be improved by numbering receipts to simplify the audit trail for staff and relatives. We saw that the home had adopted this method and receipts relating to the expenditure of people using the service were now numbered.