Springfields Limited

Springfields Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Springfields Nursing Home is a care home with nursing for up to 37 older people. The service provides nursing, respite and end of life care. Some people had complex health conditions and some people had dementia.

There were 27 people living in the service when we inspected on 29 November 2016. This was an unannounced inspection.

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 breaches 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.

People are not always supported to have maximum choice and control of their lives and staff do not always support them in the least restrictive way possible; the policies and systems in the service do not always support this practice. While the service had made reference to people's ability to consent within some care records, there was conflicting information regarding people's capacity to make decisions. Where decisions were to be made in people's best interests, these were not recorded.

Improvements were needed to ensure that all risks to people's health, safety and welfare were effectively assessed and actions that were needed to reduce risks were followed by the staff and monitored by the management of the service.

Systems were in place which safeguarded people who used the service from the potential risk of abuse and staff understood the various types of abuse and knew who to report any concerns to.

Although audits were completed on medicines, improvements were required to ensure that these included all aspects of medicine processes including stock held in the service to ensure that effective checks could be completed.

There were sufficient numbers of staff who had been recruited safely and who had the skills and knowledge to provide care and support to people in the way they preferred.

People received care that was personalised to them and met their individual needs and wishes, however, records did not always focus on the person's whole wellbeing, for example, how their mood had been or any activities that they had been involved in. People were encouraged to be as independent as possible by a staff team who knew them well and where additional support was needed this was provided in a kind,

caring, respectful manner.

The provision of activities to ensure that people had enough stimulation and interaction required review to ensure that it met people's needs.

People had sufficient amounts to eat and drink to ensure their dietary nutritional needs were met and people's care records showed that, where appropriate, support and guidance was sought from healthcare professionals.

There was an open and transparent culture in the service. There were some processes in place to monitor the quality and safety of the service provided and to gather feedback. However, the management team needed to improve how they used this information to implement changes and to provide them with oversight of the service.

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.

Improvements were required in the auditing of medicines to ensure that people were receiving medicines as required.

Risk assessments were not always followed by staff and did not cover checks to be made on bed rails.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

People were cared for by adequate levels of skilled staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not make sure that people's capacity to consent to care and treatment was properly assessed and recorded to determine people's level of understanding in accordance with MCA.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Records were not always person centred.

Staff knew about people, their individual likes and dislikes and how these needs were met.

There was some opportunity to participate in social activities, however this required review to ensure that it met people's needs.

People's feedback was not always used to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service provided an open culture. People and their relatives were asked for their views about the service.

Audits were completed to assess the quality of the service; however these were not always effective in highlighting areas for improvement.

Springfields Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on the 29 November 2016 and was undertaken by two inspectors 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. Our Expert had experience of caring for older people.

Before our 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 information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with nine people who used the service and seven visitors, including people's relatives. We observed the interaction between people who used the service and the staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We looked at records in relation to six people's care. We spoke with the nominated individual for the provider, the registered manager, the shift leader, the estates manager and eight members of staff including nursing, care, and catering staff. We reviewed five staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

Improvements were needed to ensure that there was an accurate record of the amount of prescribed medicines held in the service for each person. We completed an audit of medicines to check systems were working and we found that we could not reconcile the stock count of medicines for four people. The actual amount of medicines received into the service was not counted and the balance of medicines held in stock for people had not been recorded. This meant that we were not able to check if these medicines had been given and recorded correctly. Without this information, the service were unable to carry out effective checks to ensure that people had received their medicines as prescribed.

Despite our findings, people told us that they were satisfied with the arrangements for their medicines administration. One person said, "My medication is always delivered on time." Another person told us, "I have three lots of medicines. I have never missed any."

Medicines were stored safely in a lockable trolley for the protection of people who used the service. We saw that medicines were managed safely and were provided to people in a polite and safe manner by staff. Medicines administration records (MAR) were appropriately completed which identified staff had signed to show that people had been given their medicines at the right time. The service had regular meetings with the pharmacy who supplied the medicines to discuss any concerns.

Staff had received training in medicines administration and provided people with their medicines respectfully, with consent and at the person's own pace.

Some of the risks to people's personal safety had been assessed and plans were in place to minimise these risks. This included risks associated with pressure care, epilepsy and mobility. The risk assessment for two people regarding bed rails stated that bumpers should be in place to prevent arms and legs from becoming trapped, however we saw that bumpers were not in place on these beds. Where one person was in bed without bumpers in place, a staff member told us that they thought these had been removed for cleaning while the person was supported to eat their lunch. However, on searching the bedroom was unable to locate them to put them back in place on the person's bed. The registered manager told us that the bumpers would be located and put back in place immediately and that the service would be purchasing profile beds with integral bed rails where required. We were not shown a bed rails policy and were told that this was being updated and would include the checks that staff would need to undertake to ensure that the bed rails were safe.

We recommend that the service explores current guidance from a reputable source, for example, the Health and Safety Executive, on the safe use of bed rails.

Risks to people injuring themselves or others were limited because most of the equipment, including hoists had been serviced and regularly checked so they were fit for purpose and safe to use, however more robust monitoring was required to ensure that the measures put in place were followed by the staff team, for example, that bed bumpers were in place where required.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. For example, where a person had recently had an increase in falls, a referral had been made to the falls prevention team for further investigation and support.

Records showed that fire safety checks and fire drills were regularly undertaken by the estates manager which helped to ensure staff and others knew how to reduce the risks to people if there was a fire. Where faults had been found, these had been reported and action taken to rectify. However, these checks were not completed when the estates manager was away from the service as no-one else was trained to complete these checks. This meant that there could be a fault that would not be identified or rectified in a timely manner if checks were not completed during the estate manager's absence.

People told us that they were safe living in the service and that they felt there was enough staff to meet their needs. One person said, "I feel safe as I only have to ring and the staff come straight away. They [staff] come very quickly" and another person told us, "I am alright, I feel safe, I've got a bell and they [staff] come very quick." One staff member said, "There are enough staff to support people. Everyone [staff] is busy but people are given the care they need and we have time to do what we need to do." One relative commented, "Staff are readily available. They [Springfields] are not often short staffed and now there are more staff since the management changed." Another relative said, "Staffing levels have not been a concern with the change of ownership." [The service had changed ownership in Summer 2015]. We saw that staff were attentive to people's needs and any requests for assistance were provided in a timely manner. Staffing levels were determined according to people's needs and rotas confirmed that the assessed numbers of staff were deployed. Staff were not rushed in their interactions and had time to spend sitting and chatting with people. One person had a motion sensor in place in their room and we saw that when this was activated, staff responded quickly.

Systems were in place to reduce the risk of harm and potential abuse. Staff had received training in safeguarding and were aware of the provider's safeguarding and whistleblowing procedures [the reporting of poor practice]. There was information available to staff and people about who to contact if they had any safeguarding concerns. Although the staff had not needed to report any potential abuse, they could tell us about their responsibilities to ensure that people were protected, knew how to recognise abuse and how they would report any concerns appropriately. One staff member said, "I did safeguarding training last month. I would report any concern to the nurse in charge or [registered manager]. I would let the person know that I have to report it [concerns].

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. Records also showed that checks on nursing staff were made to ensure that they were allowed to practice in the United Kingdom.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Improvements were required to ensure that the MCA was appropriately implemented. Although the service was using the Local Authority policy and guidance, this was not always being followed. The Registered Manager confirmed that an organisational policy was being developed. There were no formal assessments of capacity for three people who were using bed rails and no evidence of decisions to use bed rails being made in the person's best interests if this was applicable. This meant that people were at risk of having their movement restricted without their permission.

We found conflicting information regarding people's capacity within care records. One person's care plan said, "[Person] is able to choose what they want to eat." However, there was a capacity assessment in place stating that, "[Person] does not have the capacity to make general decisions surrounding activities of daily living." Another person's capacity assessment said, "[Person] has no ability to make decisions re activities of daily living." However, a staff member told us that the person could make decisions about what to wear, what meal they wanted and if they wanted to wear lipstick. Where people had been assessed as not having mental capacity to make certain decisions, there was no reference as to whether others had been consulted in deciding what was in the person's best interests or any evidence of the best interest decision that had been made. This placed people at risk of not being supported to make their own decisions or of receiving care and support that they did not consent to.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

Staff were knowledgeable about their work role, people's individual needs and how they were met. One staff member said, "I read the care plans so I know the person and how to communicate with them." Another staff member explained how they supported new staff during their induction, "We always go through each person's care needs." This ensured that new staff knew how to support people effectively.

New staff completed the Care Certificate, an induction, and shadowed experienced members of staff before working on their own in the service. One staff member told us, "I had an induction and I had to shadow for

two weeks and read the policies and procedures."

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were supported to improve their practice. One nurse said, "We liaise with the hospice team as part of developing and keeping our knowledge up to date with end of life care." Nurses were being supported to revalidate their training and gave examples of how they kept up to date with clinical practice through meeting regularly with the pharmacist. The registered manager used to be a tissue viability nurse and used this knowledge to keep nurses up to date.

Staff meetings were held; staff had supervision and felt well supported by the management of the service. Supervision is an opportunity for the staff member and manager to meet and discuss performance and areas for improvement. One staff member told us, "I recently had a supervision. They are once every two months and I can talk about any worries I have." Another staff member said, "[Registered manager] is aware of everything that is happening and is a lovely person to work with." They also said, "[Nominated individual for the provider] is so approachable, a very nice person and we are lucky and very happy to have them on board."

People were mostly complimentary about the food and said that they had a choice of what to eat. One person said, "I go to bed around 11.30 and have a late supper and even in the middle of the night they bring me hot water for me to make my coffee." Another person said, "The food is excellent. I am vegetarian and they always give me a choice of two meals. It is always excellent and is home cooked." A relative said, "[Person] cannot eat some things and they look after [person's] diet" However, one person said, "Food on the whole is not bad. My family put in the suggestion box that I wanted an all-day breakfast but I only got it once. I never see bacon, egg or sausage for breakfast. I get an omelette or scrambled eggs for supper but never a bacon or egg buttie." They also commented, "Toast is nearly always cold. They wrap it up in foil but sometimes it is black and burnt, it is not great." One staff member said, "People don't have a cooked breakfast and that could be improved."

A member of the catering staff told us that an all-day breakfast was available once a month and boiled eggs were available once a week. We saw that food options had been discussed at a recent residents meeting and requests had included more fish on the menu and a cooked breakfast more often. The nominated individual for the provider told us that the requests would be considered.

At lunchtime we saw that people had a choice of two meals, one of which was home cooked. All the meals were nicely presented and brought to the table covered to keep the food hot. People were encouraged to eat independently and staff promoted social interaction where possible. Staff were encouraging and there was lots of conversation. Where one person was not eating much, the staff member sat beside them, encouraging them gently saying, "Try a bit more, how about a drink?"

People's records showed that people's dietary needs were assessed and met. Where issues had been identified, such as weight loss, this was closely monitored and action taken where required, for example, one person was not eating much at certain times of the day and so was being encouraged to eat more at times when they were hungry. Guidance and support was requested from health professionals where required, including a dietician, and their advice was acted upon. For example, providing people with food and drinks to supplement their calorie intake.

People's health needs were met and where they required the support of healthcare professionals, this was provided. One person said, "Doctor comes if needs be and the chiropodist." Records showed that people were supported to maintain good health, have access to healthcare services and receive on-going

healthcare support. Where changes in people's wellbeing were identified, action was taken to seek guidance and treatment from health professionals.

Good

Is the service caring?

Our findings

People spoken with said that the staff were caring and treated them with respect. One person said, "Staff are very kind and considerate and they think ahead." Another person told us, "Carers are great, really kind and thoughtful." All of the relatives we spoke with were complimentary about the caring approach of the staff. One relative said, "Staff without exception are very caring." Another relative said, "Care is very good, well trained qualified nurses, people are getting the best care they can get."

There was a relaxed and friendly atmosphere in the service. We saw that interactions were not rushed and staff spent time engaging with people in a way that they preferred. One staff member said, "We have enough time to spend with people and give them the care that they need."

Staff communicated in a caring and respectful manner and in an effective way by making eye contact and listening to what people said. We observed interactions between staff and people to be kind and compassionate.

People were supported to maintain their independence by staff. One person's care plan said, "Take time to listen and encourage speech as much as possible." One person told us, "I get in the shower and [staff member] stays but I pull the curtain across and wash myself and they always say, "I am here if you need me", and when I am ready they do my back and legs. It is a nice experience."

People's privacy was respected by staff who communicated with people discreetly, for example when they had asked for assistance with their continence. Staff were kind and provided reassurance by explaining what they were doing. People told us that they felt their privacy and dignity was respected and they were given the time they needed. One person said, "[Staff] wash me twice a day and they do that nicely." Another person said, [Staff] help me up and let me take my time." We saw an area where a couple were able to dine in private. This showed that staff respected people's privacy.

The service had extensive gardens with peacocks living in the grounds and many of the bedrooms had direct access to the garden, some with their own flower bed. People could choose what plants and flowers they wished to have.

One person's relative told us how they respected the person's choices, for example where they wanted to spend their time. They said, "[Person] can go wherever they want. They will come and sit in the lounge and listen to the birds [budgies]. [Person] walks in the gardens. They have a choice on food and newspapers."

People's choices relating to their end of life decisions were in place, and records relating to decisions around resuscitation showed that they had been endorsed by a health professional.

People's bedrooms were personalised and reflected their choice and individuality. People had the opportunity to include personal items of decoration and furnishings to personalise their space. One person said, "Got my own TV, own chair, curtains and fridge, got the gardens to look at and the sunshine flooding

in."

People told us that they could have visitors and we saw people entertaining their visitors who were welcomed by staff. One person had recently celebrated a birthday and said, "I have visitors when I want, no restrictions on numbers, had 61 people here for my 80th birthday and my family brought cakes. It was absolutely lovely." This meant that the risks of people becoming lonely or isolated were reduced and people's relationships with their family and friends were respected.

Requires Improvement

Is the service responsive?

Our findings

Daily records were completed at the end of each shift by staff members. They did not always provide information on a person's whole wellbeing, such as any social activities they had been involved in, how they were feeling or any positive information about the person. For example, one daily record said, "No verbal aggression noted." And another said, "Quite verbally aggressive this morning when given personal care." There was no information detailing how the staff had supported the person, or any possible reasons why the person was not happy so that the staff could try different approaches to determine if this was more suitable for the person.

The newsletter which the service produced encouraged people and their relatives to provide feedback by using the suggestion box. We saw that sanitisers were put in the reception areas and name badges were being ordered for staff following some feedback that had been received. Feedback was also sought through annual surveys. However, it was not always clear if action had been taken following feedback that had been given. For example, when people had requested more cooked breakfasts. Comments from the surveys received included, "The dining room is not always warm enough" and, "More activities would be nice." We were not shown any evidence that this information had been used to improve the service. One relative said, "Not sure they have residents/relatives meetings. I've not had any forms asking for my views." The registered manager told us that a relatives meeting had been held once, but was not well attended so they spoke to people informally instead. However, the registered manager told us that these discussions were not recorded. Relatives surveys had been sent out in the past but not in 2016. The PIR highlighted that one area for improvement was gathering information and assessing feedback from people and relatives and that this will result in an action plan to improve the service. The registered manager confirmed that this was being put into place.

People told us that there were social events that they could participate in. The newsletter which was produced gave people information about forthcoming events at their home, for example, a visit from the hand bell ringers. We saw photographs in the newsletter of one person holding a snake and others enjoying afternoon tea and a coffee morning. We saw that those who were cared for in bed had enjoyed a visit to their bedrooms from some miniature ponies.

People were provided with some activities to reduce the risks of boredom and isolation. Activities took place three mornings a week and an activities co-ordinator was in post. Photographs in the newsletter and in the lounge showed people making peppermint creams, taking part in a scarecrow competition and having a talk about birds. One staff member said, "There could be more activities but people do what they want to do and people are stimulated enough. We have a movie evening starting soon." Full consideration needs to be given to how people cared for in their rooms can be supported with meaningful activities. Whilst some interaction was logged , we saw minimal activities happening for people on the day of inspection and a lack of consideration in care records regarding the impact of social isolation and how this could be addressed to support people's holistic care needs.

Despite this shortfall, people told us that they received personalised care which was responsive to their health and personal needs. One person said, "I like to watch tv, have my meals here in my room which is my choice and I have my newspaper delivered and I walk in the gardens." A relative said, "[Person] is always very clean and tidy, as is the room. It puts my mind at rest that [person] is well cared for here." Another relative commented, "No concerns on [person's] safety, wellbeing or welfare." A third relative commented, "The home is very good and in the summer [person] can go out into the grounds and [person] loves the peacocks."

Care plans covered areas such as mobility and communication and provided guidance for staff in how people's needs were to be met. People had life histories within their records and staff knew about people, their individual likes and dislikes and how these needs were met. People and their relatives told us that staff knew them well and cared for them according to their preferences. For example, we heard one staff member singing in the bathroom while supporting one person to have a bath. Another staff member who was walking past told us that the person loved to sing in the bath.

Although the service had not received any complaints, people and their relatives told us that they knew how to make a complaint and that their concerns and complaints would be listened to There was a complaints procedure in the service, which explained how people and visitors could make a complaint and how this would be managed. One person said, "I would complain to staff but I have no complaints." Another person told us, "If I had concerns I could speak to one of the staff and they would call my family."

Requires Improvement

Is the service well-led?

Our findings

There were some gaps in how the service assessed and monitored the quality of its provision. While there were some quality assurance mechanisms in place, these had not always been effective in identifying areas for improvement, such as the concerns with bed rails, the recording of information within daily records, and the contradictory information regarding capacity. While some improvements had been identified by the registered manager, it was not always clear what action had been taken to address these or that action had been followed through. Meeting minutes showed that staff were encouraged to discuss any concerns they had. However, it was not always clear from the minutes what action had been taken to address any concerns.

The registered manager recognised that improvements were required and was in the process of compiling an action tracking form for the service to allow them to record any issues, identify actions required and implement timescales within which the actions needed to be completed. This would also provide clear oversight of the service so that any trends and themes could be monitored and action taken as required.

People knew who the nominated individual for the provider and manager was and told us that they felt that the service was well-led. Feedback from relatives about the staff and management team were positive. One person's relative said, "[Registered manager] listens, acts and does what needs to be done and is charming. Staff stay because of [registered manager]. They never panic, never raise their voice. Another relative said, "It is well run, constant care, no emergencies as it is always calm and relaxing."

The registered manager was very visible in the service and had worked as part of the team when the service had required this. The Registered Manager provided clinical oversight and support where required. Staff spoke highly of the service and were proud of it. One new staff member said, "From what I can see the service is well led. No-one has complained to me about anything. The manager is approachable and I can definitely be open and honest." Another staff member told us, "The service is well led. We all work as a team and we can input our suggestions." The staff member gave an example of a suggestion that they made which was implemented.

Annual surveys were completed by people and professionals for feedback on the strengths of the service and areas for improvement, and the results were mostly positive. One survey from a professional said, "I have an excellent working relationship with the staff and management of the home." Another said, "Excellent service, great team and lovely environment."

We saw thank you cards that had been received by the service and compliments which included, "[Person] was very happy at Springfields and the calm and quiet environment it offered. You have wonderful caring staff." Another compliment said, "Thank you for all your help and kindness during my stay with you. You were wonderful, five star."

The registered manager kept up to date with best practice through the CQC website and team meetings involving senior managers within the organisation. They were also involved with PROSPER which is a project

led by the local authority that aims to improve safety and reduce harm for people in care homes.

The service worked in partnership with various organisations, including district nurses and the local hospice to ensure they were following correct practice and providing a high quality service. One professional said, "If I have ever asked for help or needed a care plan followed, it has been done."

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that we had been notified appropriately when necessary.

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 11 HSCA RA Regulations 2014 Need for consent Capacity assessments were not always completed and best interests decisions were not always formally recorded where applicable. Where capacity assessments had been completed, this information conflicted with care records.