Scio Healthcare Limited

Springfield Nursing Home

Inspection report

26 Arthurs Hill
Shanklin
Isle of Wight
PO37 6EX

Tel: 01983862934
Website: www.sciohealthcare.co.uk

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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 21 December 2016 and was unannounced. Springfield Nursing Home provides accommodation and personal care for up to 46 adults, including people with dementia and physical disabilities, who require nursing care. There were 38 people living at the home when we visited.

There was a registered manager at the home. 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.

The provider's quality assurance procedures were not sufficiently robust. They had failed to identify the areas of concern we found in relation to the way restraint was being managed and that pressure relief mattresses were set incorrectly meaning that people were placed at risk harm. The quality assurance systems also failed to identify that people had not received their prescribed topical creams appropriately and records of their administration were not accurately recorded or up to date. Reviews and audits of care plans and related records had failed to identify that information within MCA assessments did not always correlate to the information held within other sections of the person's care plan and had not been amended as people's needs changed or reviewed on a regular basis.

Procedures for the use of restraint had not been followed placing a person at risk of harm. Otherwise people were protected from the risk of abuse and staff knew how to identify, prevent and report abuse.

Not all risks were managed safely although immediate action was taken by the provider to rectify these concerns. With the exception of prescribed topical creams medicines were managed safely and people received these when they required them.

People and external health professionals were positive about the service people received. People were also positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals. There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. The registered manager and provider were aware of key strengths and areas for development of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Procedures for the use of restraint had not been followed placing a person at risk of harm. Otherwise people were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency and systems.

Not all risks were managed safely although immediate action was taken by the provider to rectify these concerns including the correct use of pressure relief mattresses. With the exception of prescribed topical creams medicines were managed safely and people received these when they required them.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff understood and followed legislation designed to protect people's rights and freedom and ensured people's human and legal rights were respected. People received the personal and nursing care they required and were supported to access other healthcare services when needed.

People received a varied diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

The environment was appropriate for people with on going improvements including redecoration and refurbishment when required.

Is the service caring?

Good

The service was caring.

Staff knew people well, interacted positively and supported them

to maintain relationships with family and friends.

Staff understood the importance of respecting people's choices and their privacy. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

When untoward incidents or accidents occurred, procedures were in place to review these and reduce the risk of future similar incidents.

People were offered a range of activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance procedures were not sufficiently robust and had failed to identify the areas of concern we found.

People and their relatives felt the home was well managed. Staff understood their roles, were motivated, worked well as a team and felt valued and supported by the management team.

The service had an open and transparent culture with staff views being valued and where appropriate practices changed following staff suggestions.

Springfield 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 inspection took place on 21 December 2016 and was unannounced. The inspection was undertaken by three inspectors.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered manager 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 spoke with 13 people living at the home and 16 visitors. We spoke with the members of the providers management team, the registered manager, deputy manager, two nursing staff members, seven care staff and ancillary staff including the receptionist, training manager, activities staff, the chef, catering manager and housekeeping staff. We also spoke with three visiting health professionals and with five other health professionals by telephone. We looked at care plans and associated records for ten people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

The home was last inspected in February 2014, when we did not identify any concerns.

Requires Improvement

Is the service safe?

Our findings

The provider's restraint policies and procedures were not being followed where a person was being restrained to ensure they received essential personal care. This was resulting in the person and staff being harmed. The provider had arranged for 12 staff members to receive training in the use of physical intervention techniques which they could employ if necessary when supporting the person. When we spoke with staff, they told us the techniques had not been effective as they and the person were continually being hurt or bruised when using them. When we spoke with the person, we saw they had bruising to their wrist, but this had not been brought to the attention of managers, so they could not investigate how it had occurred. The person's care plan did not specify which particular techniques should be used, the circumstances in which it was appropriate to use them, or how their use should be recorded and monitored. The only written advice focused on preventative approaches and methods of de-escalating situations. The provider had a 'restraint policy' which required staff to document every use of physical intervention in a 'bound book', but this was not being done. The training manager told us any use of restraint should be recorded on 'behaviour charts' and reviewed daily by management. We saw these recorded when the person had and had not been 'compliant' during personal care, but did not specify what, if any, restrictive interventions had been used and there was no record of these being reviewed daily by senior staff. Therefore the provider was unable to confirm that the restrictive interventions were necessary and proportionate to support the person with their personal care needs. We discussed this with the directors and the registered manager, who said they would review their restraint policy and its application in this case.

The failure to ensure that correct procedures were used when people were restrained resulted in injuries being sustained which is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been undertaken to identify people who may be at specific individual risk with a view to taking action to reduce or manage the risk. These included, the risks to people falling, choking, malnutrition and skin damage. However, procedures had not ensured that the systems for managing all risks were consistently followed. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure mattresses require to be adjusted to reflect the weight and position of the person using the mattress to ensure the correct amount of support is provided. We found that pressure relief mattresses were set incorrectly placing people at risk of pressure injuries. Staff told us there was no formal procedure to monitor and ensure these were being used correctly. Although procedures had not ensured equipment was used correctly no one had developed pressure injuries. Following the inspection the registered manager told us new procedures had been put in place to ensure these mattresses were used correctly and ensure the safety of people. People were assisted to change position regularly to reduce the risk of pressure injury and nobody had developed avoidable pressure injuries. Moving and handling assessments clearly set out the way staff should support each person to move. These assessments correlated to other information in the person's care plan. Care staff were able to describe how they supported people to move safely as detailed in people's individual care plans. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance.

Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets and drinks to reduce the identified risk. The registered manager had ensured staff were aware when new procedures were required to reduce and manage risks to people. For example, staff were aware of a risk associated with fluid thickening powder. Although specific individual risk assessments had not been completed we saw that action had been taken to ensure this was managed safely and that fluid thickening powder was kept out of reach of people.

Risk assessments had been completed in respect of the environment. However, people's safety was compromised as a first floor fire exit was not alarmed. This meant staff would not be aware if people left the building unsupervised or were at risk of falling down the fire escape steps. The fire exit led to a steep flight of stairs that people with limited mobility would struggle to navigate safely on their own. We discussed this with a director and they took immediate action to install an alarm on the door. Otherwise risk assessments were completed for all aspects of the environment and measures identified to reduce the likelihood of harm. For example, the temperature of most hot water outlets was regulated to prevent scalding. Where hot water regulators were not fitted there were no risks to people as they were being cared for in bed and were not able to access the sink. The provider had plans to install regulators on these sinks as part of the maintenance programme. Arrangements were in place to check that gas and electric systems were maintained and in good condition. Equipment such as hoists and lifts were serviced regularly to help ensure they were in working order and safe to use. Where remedial action was needed, this was completed promptly.

People did not receive their prescribed topical creams appropriately and records of administration were not accurately recorded or up to date. We viewed the topical cream charts of five people and found that they had not been recorded as administered. Prescribed topical creams were kept in people's rooms along with guidance for care staff about which creams had been prescribed and when and where these should be applied. One cream chart viewed was confusing and it was not clear what cream was needed or where it was to be applied. For other people not all prescribed creams were available in their rooms or were not the creams stated on the cream charts. Once opened topical creams must be used within a specified time. However, the date of opening had not been recorded on all prescribed creams meaning staff would not know when they should be replaced. It was unclear if topical creams had been applied as prescribed. Charts had not been ticked or signed to record that the creams had been applied. For example, some stated cream was needed twice daily but showed that people had not been given their prescribed cream correctly or at all for a number of days. Following the inspection the registered manager wrote informing us that they had taken action to ensure people were now receiving the prescribed topical creams safely.

Otherwise, people received medicine safely, as prescribed and on time. Medicines administration records (MAR) for all medication, except topical creams, were completed and no gaps were identified. MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicine were required to initial the MAR chart to confirm the person had received their medicine, which they had done. Guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. Where people were not able to state they were in pain, a pain assessment tool was used. We saw that PRN medication had been given to people and the reasons why this had been administered had been accurately recorded.

Medicine was only administered by trained nurses. Staff administering medicines had received appropriate training and had their competency assessed. This included observation of a complete medicine round, together with a discussion about key aspects of the medicine management procedures. Staff were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure that the medicine had been taken. There were also effective processes

for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. We checked the stocks of some medicines and found these were accurate. We spoke with one registered nurse about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration and had yearly competency assessments.

There was a procedure in place for the covert administration of medicines, although no one was having medication covertly at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. Two nurses described the procedures which would be used. These would protect people's legal rights and ensure that all relevant people including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly.

People told us they felt safe at Springfield Nursing Home. One person said "The staff are really patient, if I need anything I only have to ask". Another person said "Safe, oh yes very much so". The majority of visitors also said they felt their loved one was safe at Springfield Nursing Home. Staff had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. One member of staff told us "If I had any concerns about the care and treatment of the residents, I would go straight to the manager". Another staff member told us "I would not hesitate to take matters further if I needed to and would go to CQC or the safeguarding team directly". Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. The registered manager took their safeguarding responsibilities seriously and worked closely with the local safeguarding authority to protect people from harm. They had recently attended a four day course to equip them to lead enquiries into safeguarding incidents.

There were plans in place to deal with foreseeable emergencies, including an adverse weather plan to help ensure staff could get to and from work. Weekly checks of the fire safety equipment were conducted, together with regular fire drills. Staff knew what action to take in the event of a fire. Personal evacuation plans had been developed and included details of the support people would need if they had to be evacuated from the building in an emergency. Following consultation with the fire officer, the provider had reviewed their evacuation procedures and was planning to install a new alarm system that would help identify the exact location of any fire. This would mean that staff would be able to take more effective action in an emergency.

Most people told us there were enough staff to meet people's needs. Comments from people included "There appears to be enough staff, they always answer my bell quickly". Whilst another person told us "On the whole the staff are pretty good although sometimes they are pushed so they can't always get to me when I need them". Relatives also gave us mixed views about staffing. One relative said "The staff are busy and overstretched at times but they are there when [relative] needs help, they constantly check he has everything he needs". Another visitor told us "The staff are good but there is not enough of them". Visiting health professionals told us there was always a staff member available to support them.

Staff told us their workload was manageable. One staff member told us, "There are usually enough staff, unless more than one goes sick; that rarely happens, but if it does, the nurses help out." Another staff member said, "On the whole there are enough staff and we have an extra hour [of care staff support] in the afternoons now, which helps." Whilst a third said "There was enough staff until recently as someone was admitted that required a lot of assistance and keeps ringing the bell. We could do with one more member of staff to manage this". During a busy period in the morning we saw call bells were answered promptly. We

saw staff responded quickly and compassionately to people's requests for support throughout the inspection.

The registered manager told us staffing levels were based on the needs of people using the service, together with feedback from people, relatives and staff. When setting the staffing rotas, they took account of the skill mix to help make sure staff with the necessary qualifications and experience were available throughout the day. As a result of recent feedback, the registered manager was planning to further increase the staffing level in the afternoons, to provide more support to people at this time. Prior to admitting new people, the registered manager completed an assessment of their needs. They told us they would not accept anyone whose needs they could not meet, unless additional resources were provided by the Clinical Commissioning Group (CCG) or the provider. Staff absence was usually covered by existing staff working additional hours; this benefitted people as they were cared for by staff who knew and understood their needs. However, staff working at other homes operated by the provider could be asked to cover at Springfield. To help facilitate this, the provider was harmonising policies and procedures across their homes, so staff would be familiar with the working practices.

There was a suitable recruitment procedure in place to help ensure staff were appropriate for their role. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions. Files for recently recruited staff showed all necessary checks had been completed, including checks to verify their entitlement to work in the UK.

Good

Is the service effective?

Our findings

People told us staff asked for their consent before providing care. One person said "They always ask if I'm ready to get up or have a wash." Another person told us "If I say I don't want to get up, that's ok; they [care staff] say 'let us know when you are' and then they come back later". Care staff told us how they offered choices and sought consent before providing care and were able to describe what they would do if someone refused care. One care staff member said "I would encourage and reassure and if that did not work I would leave them and return later".

Some people living at Springfield Nursing Home had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training and understood the Mental Capacity Act (2005) and their responsibilities within this. One care staff member told us "People have a choice, but if they can't choose we always tell them what we are going to do".

Where necessary an assessment of the person's ability to make decisions had been completed however, these had not been amended or updated with most viewed being dated 18 months previously. For one person a best interest's decision had been made in August 2016 around the use of restrictive interventions to provide personal care. The MCA assessment (that should have preceded the best interests' decision) was not clear. The only MCA assessment form on file had been completed 18 months previously (in 2014) and had been used to assess a multitude of decisions at the same time. The person's mental capacity had reportedly changed significantly since then, so a new MCA assessment for the decision to receive personal care including restrictive practices should have been completed, and assessments for other areas should have been reviewed. Some of the information within other MCA assessments did not correlate to the information held within other sections of the person's care plan and had not been amended as people's needs changed. For example, one person's assessment stated they could make decisions about receiving personal care but this had been included in a general best interest assessment covering other areas of care. Discussions with a senior nurse, the person's care plan and daily recordings made by care staff showed that another person was able to make simple decisions such refusing food and drinks however their MCA assessment did not reflect this.

The registered manager acknowledged that this was an area they needed to improve and following the inspection they informed us that all MCA assessments were being reviewed and would in future be reviewed yearly and updated when necessary.

People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met. Senior staff were aware of who they should contact at the local authority should they require advice in respect of MCA or DoLS.

People received the personal and nursing care they required and that they received the personal care in a way that met their preferences. For example, one person told us they were "Offered a shower every day". Another person said "The staff are very good, if I need help they always provide it." A visitor told us they were happy with the way their relative's health and personal care needs were met and their loved one always looked well-groomed and received regular baths. Staff recorded the personal care they provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. One visitor told us "When [relative] came to Springfield they were almost catatonic, they came here and came back. [Relatives] health has really improved". All relative's we spoke with told us health professionals such as GP's were contacted when required.

Records viewed showed people with wounds which required redressing or specific care were receiving the care they required. There were wound management plans in place which specified the care and dressings required. One person told us nursing staff had been checking their dressing daily and it had not needed to be changed since admission two days previously. Another person had chronic leg ulcers which required regular dressing changes and caused the person immense pain. There was a wound management plan in place, body maps and clear guidance around pain and wound management and we saw their dressings were clean and dry. We discussed wound management with a senior nurse who said the nurses and management decided which dressings should be used and would contact the tissue viability nurse for advice if needed.

The majority of people told us they enjoyed their meals and confirmed they received a good choice every day. One person told us "They always give us a choice and you could ask for something else". They added that the food was very good. A visitor said, "I've had meals here myself and it was good". Another relative said "The food seems really nice". The provider's Quality Assurance survey showed three people were not satisfied with the meals provided. In response, the catering manager had spoken with the three people directly in an effort to better meet their needs. Meals, including those which had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink. Staff told us they could provide people with food or hot drinks at any time this was requested or required and records confirmed this occurred.

Staff, including kitchen staff, were aware of the specific dietary needs of individual people. For example, kitchen staff were aware of which people required their meals in a softer format or had dietary restrictions due to a medical condition. People with special dietary needs were provided with menus to choose from which contained foods suitable for them and systems were in place to remind staff which people would require a higher level of support with meals. Staff members correctly told us people who required their meals in a softer texture and their drinks thickened to a specific consistency. This information was also included on the printed handover sheet provided to staff. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional

risk assessments were in place. Where necessary records of the amount people had eaten or drunk were kept meaning senior staff could monitor people's intake and consult external professionals where necessary. We saw this had occurred where there were concerns about a person not eating and the GP had prescribed nutritional supplements.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. People received the appropriate amount of support and encouragement to eat and drink. Where people required more support this was provided patiently, giving people time to finish one mouthful before they were offered more. Staff were attentive to people and whilst promoting independence, noted when people required support. For example, we saw one person had been provided with high sided crockery which enabled them to eat independently. This showed people were provided with the appropriate tools to help them overcome their difficulties.

Two people were receiving their nutritional needs via a tube directly into their stomach as they had been assessed by the Speech and language Therapists (SaLT) as not being able to safely swallow. Care plans contained clear recommendations from the dietician as to how their nutritional needs should be met including the amount of fluid they should receive each day. For one person the dietician had changed the amount of additional fluids they should receive, however this had not been amended on the MAR chart where this was recorded. A senior nurse took immediate action to update the MAR to ensure the correct fluid was provided via the tube. Although this person had not been given appropriate amounts of fluid via their feeding tube they were able to receive some fluids by mouth which they had received to meet their hydration needs.

People's needs were met by staff who were skilled and suitably trained. One person said of the staff, "They're very good really; they have an impossible job." Another person told us "I think the staff are efficient and well trained". Whilst a relative said "The nursing staff are excellent". Community health professionals told us they felt staff had the knowledge and skills to meet people's needs.

New staff completed a comprehensive, three-day induction course. They then worked alongside more experienced staff until they had been assessed as confident and competent to work alone. Their progress was reviewed after a month and then at three monthly intervals for the remainder of their first year. Arrangements were in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. All but one staff were up to date with the provider's mandatory training. This included safeguarding, moving and handling, fire safety, infection control and dementia awareness. A high proportion of experienced staff had also completed, or were undertaking, vocational qualifications in health and social care and some care staff had been encouraged to complete their nurse training. Nurses were supported to undertake study to support the needs of their registration and training to meet the specific needs of people living at the home. For example, they had attended training in end of life care, syringe drivers, catheter care and verification of death.

Staff demonstrated an understanding of the training they had received and how to apply it. For example they were able to describe how they repositioned people who were cared for in bed, were aware of reporting procedures for safeguarding and able to describe their responsibilities under the Mental Capacity legislation.

People were cared for by staff who were appropriately supported in their role. A staff member told us, "I feel really supported. The [registered manager and deputy manager] are lovely; they will always help out and are very approachable." Whilst another staff member said "I get supervision regularly and can always talk to [the

registered manager and deputy manager] if I have any issues or concerns". Another staff member said, "I feel valued and [the managers] always thank us for our hard work." All staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. A care staff supervisor had been appointed in the week before the inspection. Their role was to provide mentoring support and guidance to new staff and to oversee the work of more experienced care staff.

Staff who had worked at the home for over a year had received an annual appraisal to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the management on a day to day basis. One staff member told us "I get ongoing support and can always ask [management] if I'm not sure about something". Another staff member said "The management are really approachable".

The environment was appropriate for the care of people living at Springfield Nursing Home. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. This especially helped people with dementia to settle in and feel at home. Most rooms had ensuite facilities and many had private walk in showers. Additionally there was a choice of assisted bathrooms suitably equipped to support people with high care needs. During the inspection new carpets were being fitted to the entrance hall and hallways at the front of the home and the management team told us redecoration and where necessary refurbishment was an on going process as and when required. We were told of plans to improve the ventilation systems in the kitchen which would benefit staff and meet hygiene standards. Externally there was a garden which had level access from the home and seating areas for use by people or relatives.

Good

Is the service caring?

Our findings

Most people and relatives told us staff were caring and had developed positive relationships with them and were positive about the care they received. One person told us, "The staff are very nice and really caring". Another person said, "The staff are really patient, if I need anything I only have to ask". A family member told us, "The staff are really friendly and make us [relatives] feel really welcome". We read in a selection of thank-you cards sent by relatives which included comments such as "Thank you for all your kindness and care". A few people told us of occasions when some staff had not made them feel valued however, they also gave examples of when other staff had been excellent. Health professionals were positive about how staff cared for people and felt people were treated with respect.

We observed people were cared for with respect and warmth. For example, we heard a person being offered a drink in their room (behind a closed door). They were clearly struggling to manage the drink, so the staff member offered to get a straw for the person, which they accepted. The staff member was patient and kind with the person throughout the interaction. At lunch time people were asked where they would like to sit and offered a choice of drinks. Where there was a delay in a person's meal arriving they were reassured and informed what was happening. Staff also apologised for the delay.

People confirmed their privacy was maintained during personal care. One person told us staff, "always shut the door if they are doing anything". Another person told us staff kept them covered with a towel as far as possible when providing care. We saw bedroom doors were closed and signs were used on bedroom doors when personal care was in progress. This alerted anyone not to enter and helped protect people's privacy and dignity. Staff were able to describe how they would maintain a person's privacy and dignity. "I would always ensure that the [person] is covered as much as possible during person care". "I would always close the door and curtains". Care staff told us which people preferred care from staff of a specific gender and this preference was respected. Care plans identified if people had a preference for the gender of staff providing personal care.

People were supported without restricting their independence. One person was supported to continue to manage their own medicines. They had been provided with a secure place to store their medicines and nursing staff had completed a formal assessment of their ability to manage their medicines independently. Some people required specialised cutlery and crockery to enable them to remain independent with eating and this was provided.

Privacy was protected as personal information was kept secure. Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

People and when appropriate, people's families were involved in discussions about developing their care plans. The care plans were individualised and contained information about the person's life, including their past occupation and personal preferences, such as the time they liked to get up in the morning. Information

was also included about people's spiritual needs such as religious beliefs and the people who were important to them. Each month a Christian minister visited the home and the registered manager was aware of how to contact other religious leaders if required. People were supported to maintain friendships and important relationships. Relatives told us they could visit whenever they wished and people's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing. We were told a number of family members were planning to enjoy Christmas dinner with their loved one and had 'booked' to have their meal at the home. We were told arrangements were being made to ensure family groups could enjoy the celebrations together.

Family members confirmed they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said, "They [staff] tell us of any changes; for example, if they have asked the doctor to come out". Another visitor said of the staff, "We are always kept informed of what is going on". Where appropriate, relatives were supported to continue to provide some care for their loved one. We saw a visitor supporting a person with their lunch showing that they were enabled to maintain their relationship and feel that they were involved in the care of their relative.

Staff also provided support to family members when it was required. One family member told us how they had identified a need for a family support group and they were supported with this by the home's management who provided a room and refreshments for the group. The group aimed to provide support for each other and also identify ways that the service could be improved. The relative told us that the response from the managers had been positive to suggestions they had made in relation to menus and meals provided.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. Nursing staff had attended training to enable them to better manager symptoms people may have at the end of their life. The registered manager was aware of who they could contact for additional support if required. Information about people's preferences for their end of life care were included within care files. Nurses were aware of how to obtain and administer symptom management medicines should these be required. Where necessary medicines to manage symptoms were held within the home so they would be immediately available should the need arise. Nursing staff were undertaking additional training to enable them to verify deaths. This would reduce the length of time required for death to be verified meaning relatives could be formally informed sooner and arrangements made for the care of the person following death.

Good

Is the service responsive?

Our findings

Nursing and care staff were aware of and responsive to people's individual needs and were able to describe the care and support required by individual people. For example, they were able to describe the support people required to meet nutritional needs or how they should be supported with moving and repositioning. Care staff involved people in decisions about how their care needs should be met. One person told us they were supported to shower as often as they wished. They used to have two showers a week, but found this tiring, so had reduced it to once a week. The person said, "We tried two [showers a week] but it was too much for me, so we dropped it to one which is fine."

Nursing and care staff responded appropriately when people's health needs changed. Care plans contained clear information for staff as to the action they should take in various situations. For example, one person had a diagnosis of diabetes. Their care plan detailed the specific action staff should take if monitoring of blood sugar levels showed these to be higher or lower than was safe for the person. Nursing staff also identified when a change in the person's medicines was required as their blood sugar levels were consistently low following a change in their special dietary regime as prescribed by the dietician. When required staff re-assessed people's health needs to ensure these continued to be met. We saw a nurse enter the room of a person who was feeling unwell. The nurse spoke very kindly to the person and asked clear questions to get the information required to establish what was wrong. This enabled the nurse to ensure the person received the correct treatment. Where necessary, such as following a fall which had resulted in the person sustaining a head injury, senior nurses told us specific observations were undertaken to identify if there were any adverse effects for the person. Where people were on antibiotics or were feeling unwell records showed that their temperature and blood pressure was taken at least daily. These measures would help identify any deterioration in the person's health and help ensure prompt treatment and care could be provided.

Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. Care staff told us they had been provided with information about new people admitted to the home and received updated information about existing people should their needs change. Springfield Nursing Home was commissioned by the local NHS to provide a rehabilitation service for up to five people. These people were complimentary about the service they were receiving and felt their needs were being met. Rehabilitation community health professionals were also complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

Care plans were well organised and provided comprehensive individualised information for staff, which corresponded to the care people were receiving. Care plans contained information about how people's individual personal care needs should be met and about how people may communicate in a non-verbal way. This included individual guidance for staff about interpreting what a person's behaviour may mean, or how a person may indicate they did not want care or food. A process was in place to ensure care plans were reviewed every month by a member of the nursing team. We saw records showing this had occurred along with other amendments to care plans when these had been required. The registered manager told us they

had been working to make the care plans more person-centred and had also made the care plans more 'carer friendly' by re-formatting the summary sheet (which they called 'grab sheets') to provide a clearer overview of the person's needs. A copy of the summary sheet was seen in people's bedrooms meaning care staff would be able to quickly access these if they needed to check information whilst providing care.

Nursing staff were kept up to date about people's needs and any changes to these through a handover meeting at the start of each shift. Nursing and care staff had access to a typed handover sheet which provided relevant and individual information to help ensure people's needs would be met. Information on the handover sheet included, '[Person] must have pillows supporting their arms and legs', '[Person] can get anxious, lots of reassurance required' and 'Please ensure [person] is helped to wash their lower half'. Handover sheets were informative and included any special requirements a person may have, such as, if someone required their food/fluid intake recording, were at risk of falls, information about mobility and any equipment required. There was a comments area for priorities which were in red such as 'low fat diet needed', or where care staff were required to monitor specific aspects of care provided such as 'high risk of constipation-please monitor bowels daily'. Nursing staff demonstrated that they knew people well including their individual likes and dislikes. For example during a handover, they talked about a person who had a reduced appetite and shared ideas about how this could be managed.

Staff had information as to how they should respond to medical emergencies. Staff knew what action to take in the event of a medical emergency although systems to check emergency equipment had not identified that some single use disposable equipment included with the emergency equipment was past it's safe to use by date. The registered manager took immediate action to ensure this was added to the regular checks which were undertaken on emergency equipment. Staff had been trained to deliver first aid and use a defibrillator that had recently been installed at the home.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. All accidents were reviewed by the registered manager to identify action they could take to reduce the risk of recurrence. For example, one person had slipped through a hoist sling that was too big for them. As a result, new procedures were introduced to provide each person with their own sling, of the right size, and for staff to check each sling before they used it. Should people fall whilst moving about the home the registered manager reviewed the circumstances. This included a review of all the factors that could increase a person's risk of falling using a nationally recognised falls risk assessment tool. The directors had also started monitoring the frequency of falls across all their homes to identify when and where they were most likely to occur. No trends had been identified in the time they had been doing this, but they were clear about the action they would take if any pattern emerged. These actions would help reduce the risk of falls both individually and within Springfield Nursing Home and help ensure people's safety.

People were provided with appropriate mental and physical stimulation through a range of varied activities. A relative told us "There is lots of choice of things to do" and a person said "There is always something going on". People and their families were kept informed of up and coming events and daily activities though activities notices displayed throughout the home and in people's bedrooms. Activities included; games, music, armchair exercises, word games, quizzes, arts and crafts and afternoon tea. People were visited weekly by the 'Pets as Therapy' service and a local animal sanctuary visited regularly. Events were held such as coffee mornings and church services.

Springfield Nursing Home employed an activities co-ordinator and also purchased external entertainment, such as singers to visit the home. Activities were provided both in groups and individually. People who remained in their bedrooms by choice or through care needs were given the opportunity to receive one to one activities of their choice. Care plans included information about people's previous hobbies, interests

and life histories meaning staff could incorporate these into activities and when talking to people. Positive links had been developed with the community. These included support for the local Alzheimer's café, which people had previously attended (though none did at the time of the inspection). A staff member had recently completed a sponsored walk to raise funds for the Alzheimer's Society.

The provider sought feedback from people, relatives, staff and external professionals through the use of questionnaire surveys. Responses showed a high level of satisfaction with the service provided. Where issues were identified, these were investigated and used to improve the service. For example, some people had identified the need for more staff in the afternoon and this was achieved by bringing forward the start time of one of the evening care staff members. In addition, one of the directors held an 'open door' day to provide an opportunity for people, relatives and staff to discuss concerns or improvements they wished to see.

People knew how to complain or make comments about the service and the complaints procedure was displayed in the entrance hall. Most relatives and people told us they had not had reason to complain but would contact a staff member if needed. One relative told us they had raised an informal complaint and felt that this had been responded to appropriately by the registered manager. Other visitors told us they had raised minor issues with the management team which showed they felt able to discuss concerns even if they were of a minor nature. Records showed that complaints were used to develop and improve the service. For example, a complaint about the use of a hoist sling had led to safer working practices.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance procedures were not sufficiently robust. They had failed to identify the areas of concern we found in relation to the way restraint was being managed and that pressure relief mattresses were set incorrectly meaning that people were placed at risk of harm. The quality assurance systems also failed to identify that people had not received their prescribed topical creams appropriately and records of their administration were not accurately recorded or up to date. Reviews and audits of care plans and related records had failed to identify that information within MCA assessments did not always correlate to the information held within other sections of the person's care plan and had not been amended as people's needs changed or reviewed on a regular basis. Improvements were required to ensure that effective quality assurance systems are in place and consistently applied across all areas. The failure to ensure that correct procedures were used when people were restrained resulted in a breach of a Regulation of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider's quality assurance system assessed the service against the five key questions we ask about services and involved audits by the registered manager and the provider. Areas covered by the audits included: medicines management; infection control; care plans; food and fluid chart; and call bells. Where the quality assurance system identified changes were required, specific actions were developed and implemented. For example, the infection control audit identified the need for kitchen staff to complete training for the use of substances hazardous to health and we saw this had been done.

People told us the service was well-led. One relative said "The home is fantastic and the staff are lovely". Another relative said "We are always kept informed of what is going on". People and relatives were aware of who the registered manager was and said they felt able to approach them if they had any concerns. One relative said "[name registered manager] is very good and [name deputy manager] will sort anything out". Community health professionals also commented positively when asked if they thought the home was managed well. When specifically asked they also agreed that they would be happy for a relative of their own to be cared for at Springfield Nursing Home.

There was an open and transparent culture at the home. Staff told us visitors could stay as long as they wished and records showed that notifications about significant events were reported to CQC as required. There was a duty of candour policy in place which required staff to act in an open way when people came to harm. The registered manager was clear about how and when it should be used. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

One of the directors told us, "The culture of the service is important. We try to promote an inclusive culture directed at caring for people; and one that focuses on continual improvement through evolution rather than revolution." They added: "We are part of the community and want to feel proud of what we do." From speaking with staff, it was clear they understood the vision and values of the service. One told us, "There's a

good culture and ethos. It's very open, very caring and very friendly. This is the residents' home and it's important to build good relationships with them."

There was a clear management structure in place consisting of directors of the provider's company, who took an active role in the running of the home, a registered manager, a deputy manager, an assistant manager and a care staff supervisor. Each member of the management team had specified responsibilities, which allowed the provider the time and space they needed to take an overview of the service and monitor its performance against that of other homes operated by them. One of the directors chaired the local nursing homes association; the training manager sat on a sub-group of the safeguarding board; and the registered manager chaired the 'Matrons' meetings' of managers from other nursing homes in the area. The provider was developing links with Portsmouth University to enable trainee nurses to complete some of their placements at the provider's homes. This showed an openness and a view to encouraging service development for the future as student nurse placements may encourage them to consider working within nursing homes at a future date.

There was positive collaboration between staff and management of the provider's three homes to help ensure that good practices and ideas were transferred from one to another. Policies and procedures were being harmonised between them, so staff would be able to work in any of their homes. The directors completed an 'Operations Report' every three months. This assessed the quality and safety of each of their homes, in relation to specific aspects of care delivery, and compared the results. A previous report had identified increasing levels of staff absence across the provider's three nursing homes due to sickness. This had led to the introduction of a new absence monitoring tool, training for senior staff to help them manage absence and staff being reminded of the importance of maintaining a good attendance record.

Staff understood their roles and responsibilities and worked well as a team. Records showed there was a low level of staff turnover, indicating staff were happy in their work and this was confirmed when we spoke with staff. One told us, "Everyone is happy and morale is good." Another said, "We all muck in together and help out wherever we can." A third staff member said "The managers are really approachable; they will always make time for you and listen to what we have to say".

The provider operated a series of staff, management and clinical meetings to monitor the development of the service and seek the views of staff. The registered manager told us, "Staff meetings are more collaborative and interactive; we want to hear ideas from staff". Staff felt their opinions were valued and their voices heard. For example, following suggestions made by staff during one meeting, new food and fluid charts had been introduced with the aim of improving the accuracy of recording.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person has failed to ensure that correct procedures were used when people were restrained which resulted in injuries being sustained. Regulation 13 (4)(b)