Scio Healthcare Limited

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

Summary of findings

Overall summary

The inspection took place on the 20 and 27 March 2018 and was unannounced. Three inspectors carried out the inspection.

Springfield Nursing Home is registered to provide accommodation for up to 46 older people. There were 41 people living at the home at the time of the inspection. The home is a large extended property and accommodation is arranged over two floors, the ground floor offering dining and lounge areas and bedrooms. The first floor had further bedroom accommodation. All bedrooms were for single occupancy and most had ensuite facilities. Bathrooms and toilets were provided on both floors. There were three passenger lifts and stairs available to access the first floor. There was level access to a patio and flat garden area.

Springfield Nursing Home is a 'care home'. People in care homes receive accommodation, nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be well maintained throughout the inspection.

A registered manager was in place. 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.

A previous inspection of the service in December 2016 had identified that the service had breached regulations in relation to the use of restraint when a person required essential personal care. Improvements had been made.

At this inspection we found several occasions where incidents/accidents where there had been a significant impact on people had not been reported to CQC as required. This included safeguarding concerns and where people had been injured and required medical attention. This was a breach of regulations. The home had informed the Isle of Wight safeguarding team and ensured people received any necessary medical care as well as investigating the circumstances around the accident or incident to reduce the likelihood of a repeat occurrence.

Audits to check the quality and safety of the service had not identified that the entire kitchen area was unclean and visibly dirty, including the food storage areas, kitchen equipment and beverage making area. Other quality assurance systems in place were effective and where audits had identified areas that needed improvement action had been taken.

The provider had arrangements in place to protect people from risks to their safety and welfare. Arrangements were also in place to store medicines safely and to administer them according to people's

needs and preferences. People were supported to access healthcare services, such as GPs and community nursing teams.

Staffing levels enabled people to be supported safely and in a calm, professional manner. Recruitment processes were followed to make sure only staff who were suitable to work in a care setting were employed. Staff received appropriate training and supervision to make sure they had the skills and knowledge to support people to the required standard.

There were processes and procedures in place to protect people from the risk of abuse. Risks to people were managed safely with plans in place to minimise risks where possible.

Staffing levels enabled people to be supported safely and in a calm, professional manner. Recruitment processes were followed to make sure only staff who were suitable to work in a care setting were employed. Staff received appropriate training and supervision to make sure they had the skills and knowledge to support people to the required standard.

Care and support were based on care plans which took into account people's needs and conditions, as well as their abilities and preferences. Care plans were adapted as people's needs changed, and were reviewed regularly. Staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed. People and external health professionals were positive about the service people received.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs.

People found staff to be kind and caring. Staff respected people's individuality, privacy, dignity and independence. Equality and diversity were actively supported with people being able to express themselves.

People were able to take part in leisure activities which reflected their interests and provided with mental and physical stimulation. Group and individual activities were available if people wished to take part and visitors, including pets were welcomed. People were supported and encouraged to be as independent as possible and their dignity was promoted.

The home had an open, friendly atmosphere in which people, visitors and staff were encouraged to make their views and opinions known.

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.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We found one 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 back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risk of infection as the kitchen which was not clean and infection risks posed by some equipment were not managed in line with best practise guidance.

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.

Medicines and risks to people were managed effectively.

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 acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People received effective care from staff who were competent, suitably trained and supported in their roles.

People were positive about the quality of the meals and were supported to eat and drink enough.

People had access to health professionals and specialists when needed. When people were transferred to hospital, staff ensured key information accompanied them to help ensure their received ongoing healthcare support.

Adaptations had been made to the environment to make it suitable for people living there.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

Staff supported people to maintain relationships that were important to them.

Staff protected people's privacy and respected their dignity.

People and family members where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person. Care plans were reviewed regularly and staff responded promptly when people's needs changed.

People were empowered to make choices about all aspects of their lives. They had access to a range of meaningful activities suited to their individual interests.

Staff had the necessary training and commitment to support people to receive end of life care that helped ensure their comfort and their dignity.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to ensure that all necessary notifications to CQC were submitted as required.

There were management systems in place to identify and manage risks to the quality of the service. However, we found these had not identified the kitchen required further cleaning.

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

The service had an open and transparent culture. People and relatives were kept informed and involved in the service.

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 20 and 27 March 2018 and was unannounced.

The inspection was undertaken by three adult social care inspectors.

Before the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people living at the home and eight visitors. We spoke with the provider's area manager, nominated individual, registered manager, four nurses and five care staff. We also spoke with ancillary staff including, catering staff, an activities staff member and three housekeeping staff. We spoke with four visiting healthcare professionals.

We looked at care plans and associated records for nine people, three sets of records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance.

We observed care, support and activities being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in December 2016 we found the correct procedures were not used when people were restrained whilst receiving essential personal care and injuries had resulted. This was a breach of Regulation 13 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us how they had addressed this issue. At this inspection we found that the provider had taken action and restraint was only used when required and followed best practice guidance.

Since the previous inspection the staff had receive training from an external professional to ensure that where restraint was required this was completed appropriately and safety. The registered manager had updated the restraint policy and worked closely with the Local Authority Safeguarding Team to ensure this was appropriate. One person's care plan showed a clear process and guidance for how restraint should be used in line with the home's policy and demonstrated that restraint was only used when other options had failed and then only for as short a time as was necessary.

The person's behavioural chart showed that on one occasion when restraint had been used for a period of five seconds this was not raised with the Nurse on duty as per the provider's policy. We followed this up with the registered manager, who told us that they had also noted this and had spoken to the care staff involved and confirmed this should have been raised to the nurse in line with the guidance in the person's care plan.

People were not always protected from the risk of infection. The entire kitchen area was unclean and visibly dirty, including the food storage areas, kitchen equipment and beverage making area. Certain pieces of equipment were rusted and needed replacing, others required thorough cleaning. There was no hand washing facilities readily accessible to care staff who would have to pass through food preparation areas to the hand washing basin. This had not been identified during the provider's infection control audits or visits to the home. Following the inspection the registered manager sent us an action plan showing action was being taken to ensure the kitchen was comprehensively cleaned and remained clean.

When people required constant or intermittent oxygen therapy, systems were in place to ensure the equipment was used safely. However we found that tubing supplying the oxygen was not being changed on a regular basis as recommended by best practice guidance placing people at risk of infection. This was immediately rectified by nursing staff. We looked at equipment used to support people when moving and we saw evidence that the equipment was well maintained and serviced regularly. We saw that people had access to call bells so that they were able to alert staff if they required support. These were observed to be within easy reach throughout the home and in people's bedrooms.

We heard two people talking and one commented, "It's (bedrooms and communal areas of the home) very clean isn't it; they do a good job of keeping it clean." Cleaning staff told us they had cleaning schedules to follow and enough time to complete all cleaning required. The laundry was clean and well organised with procedures in place to ensure clean items were not in contact with those waiting to be laundered.

All staff had completed infection control training and had access to equipment such as disposable gloves

and aprons to protect themselves and people from the risk of the spread of infection. We saw these were used by staff when required. When people needed equipment for moving around the home or when they required repositioning in bed individual equipment was available. We saw this within people's bedrooms. People had been supported to receive the annual flu immunisation which would help prevent the spread of this disease and antibacterial hand gel was available at the entrance of and around the home. The registered manager said they had encouraged staff to also have the flu immunisation. The registered manager was aware of actions they should take if there was a potentially infectious outbreak at the home. When nursing or care staff suspected that a person may have an infection they took the necessary action to ensure this was promptly treated and acted to reduce risks to other people.

People and their family members told us they felt that Springfield Nursing Home was a safe place. When people were asked if they felt safe their comments included, "I think so. Yes", "The staff are lovely. I have no worries" and "I feel as safe here as anywhere in this day and age." A family member told us, "If I didn't think [name of relative] was safe I would not let them be here."

Records showed the registered manager had worked effectively with the local safeguarding team to undertake investigations and appropriate action had been taken to protect people from the risk of abuse. For example, one person had told the registered manager that they had some money missing. Investigations took place and procedures were reviewed to enable a change in how promptly belongings and money were booked into the home and stored to mitigate further risks. However, the registered manager had not ensured that CQC were notified of these safeguarding concerns as they are required to do. Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse.

People were protected from risks. Risks to people were minimised through the use of effective risk assessments, which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Individual risk assessments were reviewed monthly or when risks changed with a clear summary of any changes made. This ensured nursing and care staff had up to date information about the person's needs. Where individual risks to people were identified, action was taken to reduce the risk. These included the risks to people of falls, choking, nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. A senior member of the care staff team was responsible for monitoring that pressure relieving mattresses were being used correctly. We checked several mattresses and found they were being used appropriately. People were also assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments explained how staff should support each person to move. Staff had been trained to support people to move safely and we observed equipment, being used in accordance with best practice guidance. We observed care staff supporting people correctly when using wheelchairs and or walking aids such as frames. Staff confirmed that there were always two staff available when required to ensure equipment was used safety.

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. For example, one person wished to continue to smoke cigarettes. The risks and benefits to stopping were discussed but they were supported to make their own choice. They were aware they had to do this outside. Their risk assessment identified the need to ensure they were warm and always had a call bell with them. The person confirmed they were able to smoke and staff reminded them of the need to keep warm. The person showed us the portable call bell they had been provided with.

The registered manager was aware of the risks posed by a fluid thickening powder if ingested without it being mixed with fluids. Individual risk assessments had been completed for people who required this. The risk assessment stated the powder should be kept out of the person's reach. We saw staff were following this and within bedrooms fluid thickener powder was not accessible to people.

Where accidents, incidents, and near misses had occurred there was a process in place which was being followed to reduce the risk of recurrence. Incidents and accidents were all reported to the registered manager who analysed them and reviewed any relevant risk assessments and care plans as required. For example, one person had involuntary spasms and had bitten down on a plastic spoon whilst being supported to take their medicine. The person swallowed the tip of the plastic spoon. Action was taken to change the type of spoon used for all people to minimise the risk of it happening again. Another person was given hot soup in a cup with a lid. The lid came off and the person was scolded on their chin and chest. A GP was contacted and the person required dressings. The person's risk assessment was reviewed and action taken to ensure soup was not served so hot. Issues were discussed with staff during supervision, handover meetings and in a monthly staff newsletter. Important information about changes was also displayed on the staff noticeboard in the staff room. However, the registered manager had not informed CQC of all incidents or accidents where people experienced an injury which required medical attention.

People were supported to receive their medicines safely and as prescribed. There were appropriate procedures in place for the safe ordering, administering, storing and disposing of medicines. Action had been taken to ensure that topical creams were managed safely. People received their creams as prescribed and this was documented on their topical cream charts. Dates of opening had been recorded on the creams to ensure that they were not used past their recommended expiry date. Medicines Administration Records (MAR) were completed accurately with no gaps identified. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff also recorded on the MAR chart the time that medication was given to each person, to ensure that enough time was safely given between regular medications. Guidance issued by the National Institute for Health and Clinical Excellence (NICE) recommends that the MAR charts include a photograph of each person to help ensure that the right medicines are given to the right person. We found that MAR charts contained photos of residents, along with a 'front sheet' of key details such as people's allergies, preferences around taking medicines and their GP.

Medicines were only administered by trained nurses who had received appropriate training and had their competency assessed. We observed staff administering medicines competently; they did not hurry people and remained with them to ensure that the medicine had been taken. People confirmed they received their medicines and that they could request as required medicines such as for pain if needed.

The home followed a thorough recruitment process to ensure that suitable staff were employed for their role. Recruitment records showed the registered provider had completed relevant pre-employment checks before any new members of staff began working at the home. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff recruitment records also contained applications forms, health declaration, records of interviews, and references. The registered manager told us as part of the interview process prospective staff were walked around the home and introduced to people. Afterwards, feedback was sought from staff members and people to help the registered manager select appropriate staff.

There were sufficient numbers of staff available to keep people safe and ensure their needs were met. The registered manager told us staffing levels were determined by experience and feedback from people and staff, and also by the level of care people required. The registered manager told us new residents would not

be accepted into the home unless sufficient staffing levels could be safely maintained. When completing staffing rotas, the skill mix of staff was considered to ensure that staff with experience and necessary qualifications were available in all areas of the home, at all times. In the event of staff absence, this was usually covered by existing staff working extra hours. In addition, staff told us that the registered manager and deputy manager, both of whom were registered nurses, would often take on the role of covering shifts. One staff member told us "[The registered manager] will often come down and step in on the floor with us, she will get stuck in." One visiting healthcare professional told us, "The staff are always helpful and will show me to people and stay if I need any help."

Environmental risks were assessed and managed appropriately. Risks associated with the environment and the running of the home had been assessed and actions to mitigate risks put in place. All upstairs windows had opening restrictors placed on them. The upstairs fire escape was alarmed meaning that if the door was opened staff would be immediately aware and able to act to protect people. Environmental risk assessments were robust, available to staff at all times and were reviewed as and when required and as part of the providers quality monitoring procedures. They included the use of electrical equipment and fire risks. Cleaning chemicals and other substances hazardous to health (COSHH) were stored securely.

Fire procedures were robust and there was clear guidance sheets for the safe management of people in the event of a fire. The fire evacuation plan was updated every time a new person was admitted or a person was discharged from the home. Fire equipment was tested each week and different parts of the home were tested on a rotating basis. Fire extinguishers and equipment was serviced annually and were in date. Staff were aware of the action they should take in an emergency and had received relevant training. Contingency arrangements had been made should people need to be evacuated to alternative accommodation. An environmental fire risk assessment of the whole building was completed in 2017. An action plan to reduce the risks found was developed and showed action had been taken where necessary.

The service had a business continuity plan that was thorough and robust. In the event of the building not being safe for people, the other homes in the providers group on the IOW would be contacted to support by taking people to their locations if needed. There were also clear plans for contacting the CCG and Local Authority for support and guidance.

Good

Is the service effective?

Our findings

People, their families, a healthcare professional and a social care professional told us they felt the service was effective. A person told us, "I'm now much more independent." A family member told us how when their relative had been admitted they had not been expected to improve, however they were now; "Much better, back up and walking and going home today." A healthcare professional said, "The staff know what they are doing and will ask us if they are unsure."

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dieticians, speech and language therapists (SALT) and GPs. Additional healthcare support had been requested by the staff when required. Nursing staff were aware of how to contact community dentists and other health care professionals if required. All appointments, visits and communication with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and information in relation to people's health needs and how these should be managed was clearly documented within people's care files. We joined nursing staff for a handover meeting between the morning and afternoon nurses. This showed action was being taken to meet healthcare needs.

People's care and treatment was delivered in line with current legislation, standards and evidence based guidance to achieve effective outcomes. We saw a range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used nationally recognised tools to assess a person's risk of developing pressure injuries, risk of malnutrition and to monitor their bowel movements.

Care files detailed people's individual needs, showing consideration for their assessed needs and their personal preferences. Pre-assessments were carried out by the registered manager or senior nurse prior to people moving into Springfield Nursing Home. The registered manager told us that they considered if the home was able to safely meet the needs of people before agreeing to them moving in as well as the location of vacant rooms. Nursing and care staff told us they had been provided with information about new people prior to them being admitted. They said this helped them to understand the person's needs and how they should be met. Care plans showed that relatives had been consulted during the pre-admission process. One relative said, "The manager came and saw us, asked lots of questions." The registered manager said they would consult with external health professionals already involved with the person's care as part of the pre-admission assessment.

Where people had specific needs in relation to their lifestyle choices we saw through interactions with nursing and care staff and care records that their needs were being considered and met. Care staff demonstrated a good understanding of people's needs and wishes. For example, they told us how they supported people's human rights, how individual people like to be supported and what was important to them.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when

necessary. One person told us. "The food is very good here." Another person said, "The food is really good and as I have to be careful what I eat, they will make me an omelette if I ask." A relative told us "It always looks very nice and [name of person] eats it all." People received the appropriate amount of support and encouragement to eat and drink. A person asked a member of staff for help cutting up their food. The staff member did this promptly and asked if the pieces were cut up small enough before leaving them. Many people required full support with all meals and drinks and we saw this was provided patiently. Care files had information about any special dietary needs people had and if they required a soft diet or support to eat. There was also clear information about the food and drinks that people liked and did not like. Records viewed showed people were receiving appropriate food and drink. Where people were reluctant to eat and drink external health professionals were consulted and nutritional supplements were provided when necessary. The provider was aiming to increase the meal time experience for people who required their food in a soft texture. All chefs had attended additional training to introduce the use of food moulds to improve the visual appearance of pureed meals.

People had a choice of what they wanted to eat each day. There were usually two choices but the chef told us they would make an alternative if someone requested something or did not like the options offered. We saw there was a range of choice in lunches both hot and cold. One person had a salad; others had vegetables, meat and different types of potatoes. Meal times were spaced evenly throughout the day but people told us that if they asked the care staff they could have food when they wanted. One person said they usually woke up early and could get a hot drink and sandwich. Fruit, cake and biscuits were readily available at all times. People who had lifestyle and religious choices about the food they ate were respected and their choices adhered to.

The Mental Capacity Act (2005) 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.

Some people living at Springfield Nursing Home had a cognitive impairment and were not able to give valid consent for certain decisions. This included 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. Nurses carried out assessments of people's capacity and then if required would have discussions with the person's family and any other professional who may be relevant, to agree what would be in the person's best interests. There were best interest decisions around general care and treatment, and where necessary for specific decisions such as the use of movement alert mats or bed rails.

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 Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether DoLS applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLS applications had been made. There were systems in place to ensure that DoLS were reapplied for when necessary.

We saw that where people had made a Lasting Power of Attorney to manage their finances or to make decisions about their health and welfare, copies of these were kept in the home so that the nursing staff were clear who had legal authorisation to make decisions on behalf of people.

Staff worked collaboratively for the benefit of people. We spoke with ancillary staff who told us they had

completed the same basic training as care staff including emergency training, meaning that they would be able to assist other staff if required, such as during a fire. Care staff confirmed this and said they felt able to ask nursing staff for assistance if another care staff member was not immediately available. One staff member told us, "We work as a team, it's a good place to work, we work together well." The home had five beds commission by the local NHS to provide a short term rehabilitation facility. Staff from the NHS regularly worked in the home and told us the homes staff worked well with them. The registered manager said they have a positive working relationship with all the team and attend the two weekly meetings to review people's progress with the external health team. The home was supporting the local hospital to ease winter pressure on hospital beds by facilitating prompt assessments and discharges from the hospital to the nursing home. The registered manager told me they had a good working relationship with the local GP service and other community health professionals. When people were transferred to hospital, staff ensured key information accompanied them to help ensure their received ongoing healthcare support.

The environment was appropriate for the care of people living at the home. All bedrooms were for single occupancy and most had ensuite facilities with many having a private walk in shower. Additionally there was a choice of assisted bathrooms suitably equipped to support people with high care needs and located close to people's bedrooms. There was a communal lounge with additional sitting areas located around the home. Two dining rooms were provided which could also be used for group activities or private meetings if required. People could access the garden which was level and suitable for those with limited mobility. There was an ongoing programme of redecoration as required.

People's needs were met by staff who were suitably skilled and competent. New staff completed an extensive induction across three days, which included practical and classroom-based training covering relevant areas to their job role. After their induction, new staff spent time shadowing (working alongside) experienced staff members in the home, until they were assessed as competent to deliver safe care independently. Where new staff members did not have up to date qualifications in care, they were supported to complete the Care Certificate, which is a set of nationally recognised standards that health and social care staff must follow in their daily working role. Staff were also supported to complete higher level vocational qualifications when this was requested by them. The registered provider used a training matrix to record and monitor when staff were due training updates. This showed most staff were up to date with all training. Staff told us that they enjoyed the training and felt it was appropriate to help them provide effective care to the people they supported. One staff member said that they had been supported to receive additional training if they asked for it. They told us, "If I want to do something, they always listen and try to sort it out if they can."

New staff received regular supervisions with management at one and then at three month intervals to assess their progress and identify any areas of concern. Staff confirmed they received regular one-to-one sessions of supervision with management to talk about their progress. Staff employed longer that 12 months received annual appraisals, where they discussed their overall performance and development needs. Staff told us that they felt valued and well supported in their role. One staff member told us, "We get regular supervisions; it's nice to sit down and hear that you are doing a good job." Another said, "[The managers] are very approachable and supportive, they don't make you feel that they are above you."

Good

Is the service caring?

Our findings

Staff had developed caring and positive relationships with people. When a person was asked if they felt the staff were caring they said, "Oh yes, they are wonderful." Family members comments included, "[My relative] is happy, safe and well looked after" and "They [staff] go above and beyond the call of duty, they are natural carers." A person told us how staff had rearranged their bedroom to make it easier for them to see out of the large window to watch birds which fed at a bird table located outside their room. They told us staff regularly placed food on the table to encourage the birds. All people, visitors and family members that were asked confirmed that they would be happy to recommend the home to others.

People were cared for with dignity and respect and all interactions we observed between people and staff were positive and supportive. Staff were heard speaking to people in a kind and caring way and would interact with people in a positive, friendly and cheerful manner. We saw staff kneeling down to people's eye level to communicate with them. We heard good-natured interactions between people and staff, showing they knew people well. One staff member said "I love looking after the residents and listening to their stories, I have a lot of time for them." Staff were observed to allow people time to respond and did not rush them.

Nursing staff explored people's cultural and diversity needs by talking to them and their families and by getting to know them and their backgrounds as part of the pre admission assessment. Further information was gathered by the activities coordinator to help ensure any individual needs were known and met. This information was then documented within the person's care file. A senior nurse told us that if a person followed a particular faith that they and the staff lacked knowledge of they would research this by looking for information on the internet and speaking to followers of that faith to help ensure that people could be effectively supported. In one person's room that there were numerous posters and memorabilia of their favourite singer. The registered manager told us that for the person's 80th birthday, a care staff member had contacted the singer who was on tour in the area and asked if they could come to the home. As they were unable too, they had sent the person a signed CD. We saw pictures of the person receiving this which were displayed in their room.

People's privacy was respected when they were supported with personal care. We saw that signs were placed on bedroom doors informing others that they should not enter as care was in progress. A family member told us "If I arrive and see the sign I know not to go in and wait until they have finished, It's a good idea." Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. A staff member told us, "We always make sure that we respect people's privacy." Of the 42 bedrooms at Springfield Nursing Home, only two were not en-suite. The registered manager told us that when assessing people for those two rooms they took account of people's needs and only people who needed to be cared for in bed at all times were accommodated in these rooms. This was because they would not have a need for the ensuite facilities and meant people who would benefit from private facilities would be able to do so.

Information regarding confidentiality, dignity and respect formed part of the induction training for all care staff. Confidential information, such as care records, were kept secure in the nurse's office or discretely within people's bedrooms and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

People were encouraged to be as independent as possible. At meal times we saw that staff would encourage people to feed themselves and people had access to appropriate specialist equipment where required. We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their pace. One person told us "I can do most things for myself but they make sure I'm safe and do the bits I can't reach." Another person told us how staff had assessed their ability to manage their own medicines and they were now self-administering their medicines. Care plans included information as to what people could do for themselves and when support may be needed.

Where people had specific communication needs, these were recorded in their care plans and known to staff. We saw staff follow the guidance within people's care plans, including speaking clearly and giving people time to answer.

The service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and offered them choices in what they preferred to eat and where they wanted to spend their time. A staff member told us, "We always ask people want they want to do, it's up to them." The registered manager said they offered and engaged with advocacy services when people were assessed as lacking capacity and did not have any family or friends who could act on their behalf.

People and their families were involved in everything that was happening and decisions about care and support were discussed together. Each person had a link nurse and a keyworker and they were the main point of contact for them and their family. Any appointments such as GP visits etc. were discussed with the person and their family, with permission.

People were supported to maintain friendships and important relationships. Care records identified people who were important to the person. All of the families we spoke with confirmed that the staff supported their loved ones to maintain their relationships. The registered manager told us how they were organising a marriage blessing at the home as a person was not well enough to attend an important family wedding. There were no restrictions to visiting times and families could visit at any time. A family member said, "As relatives we are encouraged to come in at any time." They added, "We have been able to bring in our dog as well which [person's name] really enjoys seeing." We saw several dogs visiting people during the inspection. Another family member told us, "We are always made to feel welcome."

Good

Is the service responsive?

Our findings

People and their relatives were happy with the way the home met people's personal and care needs and told us care staff knew their preferences and respected their wishes. A person told us, "They [staff] treat us like royalty." A visitor said, "[Relatives name] has been really well cared for here, I'd book a place." Staff were flexible to meet people's preferences as to how and when their care was provided. For example, one person told us how they could get a hot drink and early breakfast as they often woke at about 5am. Another person told us "They [staff] will do anything for you – nothing is too much trouble."

Nursing staff reviewed care needs and risk assessments regularly. Care staff had access to care plan files should they need to refer to these. As well as medical and care needs information care files also contained other individual information, such as a person religious or spiritual needs and information about people and things, which were important to them. Records of the care people had received reflected the information within care files. Handover information was available to staff at the start of every shift and provided the opportunity for them to be made aware of any relevant information about changes to the needs of the people they were supporting.

When required staff were aware of the action they should take should there be a change in the needs of a person. For example, nursing and care staff were able to say what may lead them to suspect a person had an infection or may have suffered a stroke. An external medical professional told us the nursing staff were good at identifying when a doctor needed to be contacted and were able to provide relevant information to help them make a diagnosis or determine if a visit was required. During the inspection when the emergency bell sounded staff quickly responded but there was no panic. Medical emergency equipment was available which had been checked regularly to ensure it and associated equipment was in safe working order.

Medicine Administration Records contained information to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. The home also used a nationally recognised pain assessment tool to help nursing staff decide where PRN medicine should be given. However, we found for one person this was not clear. The PRN sheet stated a medicine should be given when there are signs of 'agitated behaviour', but there was no supporting information to guide staff as to how 'agitated behaviour' should be recognised for that person. We raised this with a senior nurse, who took immediate action to update the care plan with more information.

People received the care they required to remain comfortable at the end of their lives. People were supported to make choices about their preferences for end of life care and their families were consulted. Care files had information about people's next of kin and end of life details, such as the funeral provider people would want. Nursing staff had attended training to enable them to better manage symptoms people may have at the end of their life. They were aware of how to obtain and administer symptom management medicines should these be required. The registered manager was aware of who they could contact for additional support if required. We were told that when people were at the end of their life and wished to receive a visit from a religious minister, the home had 'out of hours' contact numbers so this can be arranged at short notice if required. We were shown thank you cards which had been received from relatives

thanking staff for the care that had been provided to people who had been receiving end of life care at the home. Cards also thanked staff for the support relatives had received at this difficult time.

People were provided with appropriate mental and physical stimulation through a range of varied activities. People told us they felt there was enough to do and one person showed us some craft work they had completed. Another person told us activities staff had taken them out into the garden which they had enjoyed and hoped to do again when the weather was better. On the second day of the inspection we saw an external musician entertaining a group of people in a communal area. People looked to be enjoying this activity. An activities coordinator was employed who provided individual and group activities suited to the needs of people living at the home. A monthly timetable of activities was organised and included visits by a pet therapy dog, bingo, quizzes, musicians, puzzles and films. People were informed about planned activities via the activities plan which was placed in people's bedrooms and on notice boards around the home. We heard staff encouraging people to attend activities and reminding them of what was planned. Many people were unable to attend group activities due to their complex health needs and we saw that those who remained in their bedrooms had a variety of music stations playing or televisions in use. The activities organiser also provided some individual activities for these people.

There were links with the local community. The local church came into the home to have a service once a month. They also have priests and vicars in for direct pastoral support for people when requested. The local school visited at Christmas time to sing carols and there have been events and visits from local brass bands, choirs, reminiscent groups, pet shops who brought animals for people to hold and a donkey sanctuary who brought donkeys into the garden area. The registered manager also told us about a new project they were getting involved with. This was run through a national organisation and trained volunteers from a local church to befriend people, spending time talking, reading to them and walking in the garden together. Full training and DBS checks would be carried out for any volunteers recruited.

People and visitors were kept informed about the home and any events which may affect them. The home had a monthly newsletter 'Springfield News' with events for the month, quizzes and articles. There was also a Hartford Care newsletter available for staff and visitors.

The registered manager sought feedback from people and their families on an informal basis when they met with them at the home, during telephone contact, email correspondence and during resident and relative meetings which were held twice a year. People and their visitors felt able to approach the registered manager or senior staff at any time. Their comments included, "We can always talk to the manager when we want to." The provider of the service also sought formal feedback through the use of quality assurance survey questionnaires. One person who was due to be discharged on the second day of the inspection showed us a formal feedback questionnaire they had been provided with.

People and their families told us that they would feel comfortable raising concerns and were confident that any issues or concerns raised would be acted on. A family member said, "I feel I can approach [name of registered manager] if I had a complaint." An external health professional told us that they had raised one issue with the registered manager and this had been dealt with promptly and effectively. They felt confident that any future issues would also be managed appropriately. The registered manager said they took all concerns and complaints seriously. The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. We viewed records of the two formal complaints received during the previous year and these showed that an appropriate investigation and action had been taken. The people who had raised the concern had received a written response from the registered manager.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to inform CQC about various incidents and events which occur within the home. These are called notifications. We found several occasions where incidents/accidents which had had a significant impact on people had not been reported to CQC as required. This included safeguarding concerns and where people had been injured and required medical attention. We discussed the failure to notify the CQC of these events and the registered manager recognised that this should have happened.

The failure to notify CQC of incidents which occur whilst services are being provided was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

The home had informed the Isle of Wight safeguarding team and ensured people received any necessary medical care as well as investigating the circumstances around the accident or incident to reduce the likelihood of a repeat occurrence.

Quality assurance systems in place were not always effective. These had not identified the areas of concern we found during this inspection including the infection risks relating to the kitchen which was unclean and visibly dirty and that notifications had not been sent to CQC as required. The provider had a quality assurance (QA) process that involved the quality manager for the provider conducting monthly QA audits. Each month they focused on one or two areas – such as infection control and medication. Other QA audits had been regularly completed by the registered manager. We saw that where audits had identified areas that needed improvement and action has been taken. For example, a hoist had shown signs of wear and the provider was contacted and the part replaced. The registered manager carried out unannounced checks of the home at all hours of the day or night and had worked alongside staff including at night to monitor the quality of support given to people.

People, family members, staff and professionals all described the service as well-led. A social care professional told us, "It's all very well organised." A healthcare professional said, "[Registered manager] is very proactive; they get things done." A staff member told us, "[Registered manager] is lovely, they are firm and fair." They added, "We can talk to them at any time. They listen to us, are supportive." Other staff comments included "I do love working here, it's homely; we are like a family and we work as a team" and "I love it, we look out for each other."

Staff spoke positively about the open culture and management of the service. They said they were able to raise issues and make suggestions about the way the service was provided and their suggestions were taken seriously and discussed. The management team and staff demonstrated that they had an understanding of equality, diversity and human rights in order to provide safe and compassionate care.

Shortly before the inspection there were some changes within the senior management of the providers company. The provider Scio Healthcare Limited had not changed however another company Hartford Care had purchased Scio Healthcare Limited meaning all directors and the nominated individual had changed. The nominated individual is the person who has legal responsibility for the service. Staff told us they had

met with representatives of Hartford Care and felt able to raise issues with them if required. The nominated individual told us they attended the home several times per month and were available to the registered manager and staff at another times. They were clear that they wanted to further develop the service provided whilst working with the existing management and staff team to ensure a high quality of service. The registered manager told us that one of the provider's directors had recently come to the home and had worked a shift. This was so they could understand what Springfield provided and any challenges they had. They felt that this was very positive and showed that the provider wanted to understand what the home did and to work together to deliver a good standard of care. The registered manager said that they found Hartford Care managers to be very supportive.

There was a registered manager in place. 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 registered manager was a qualified nurse who, when required worked as a nurse, providing hands on care for people. The registered manager had worked at the home for many years and felt the support and on-going training opportunities they were given were very good. They felt able to carry out their role well. We observed the registered manager speaking with staff and people with respect, kindness and patience. Staff approached them and asked questions which they were able to give clear answers or if unable to answer, asked them to speak to another relevant staff member.

The registered manager had a clear vision and strategy to deliver high quality care and support. They told us how they were committed to developing staff and were proud of care staff who were now undertaking nurse training. The home supported student nurses on placement from local universities having trained some of their nurses to be mentors. The registered manager said they hoped some of the student nurses would be interested in working for the provider in the future as qualified nurses. The home had created a new role of lead health care assistant. They were supernumerary and their role was to support and monitor the care staff team. The registered manager and the deputy manager were both supernumerary but would cover shifts if needed and to enable them to monitor the staff in their roles.

The registered manager kept up to date with relevant external safety alerts/recalls by emails from the Medicines and Healthcare Products Regulatory Agency (MHRA), the Common Alerting Protocol (CAP) service and CQC alerts. They recently had an alert, which they acted on when batteries in certain defibrillators were identified as dangerous. The registered manager took immediate action and changed the batteries to the ones recommended. This was also communicated to the staff team through handovers, supervision, staff meeting and monthly staff newsletters. The registered manager had recently attended training provided through the local hospice which was aimed to share best practice for registered managers. The providers had comprehensive and robust policies and procedures to enable staff to be clear about their roles and responsibilities and to manage health and safety.

The registered manager and senior team all had a good working relationship with local health and social care teams. The home had five rehabilitation beds under the NHS and this meant that external health and social care professionals were in the building very regularly. The senior team worked closely with them and met to discuss people's progress and changing needs.

Staff meetings were held three monthly. Staff meetings were used to share information and discuss positive outcomes as well as to identify lessons learnt when things have gone wrong. The registered manager also wrote a monthly newsletter to update staff on events, training, news etc. This was sent out with payslips and had been received well by the staff team.

A duty of candour was practiced and apologies were given to people if the home was found to be at fault, although this has not had to be used in the last year. The previous CQC inspection rating was displayed in the front entrance on a notice board and on the provider's website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider has failed to ensure CQC were notified of incidents which occurred whilst services were being provided. Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4) (1)(2)(a)(e)(f)