Mrs Margaret Blair

Springfield House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 February 2017 and was unannounced, which meant that the staff and provider did not know we would be visiting. The care home was last inspected on 17th January 2015 and we found them to be meeting all the legal requirements in force at the time.

Springfield House is a three bedded care home set in a rural location being a farmhouse that has been adapted and extended to provide accommodation for up to three people living with a learning disability. The provider's family also lived in the house. Each person had their own room and there was a separate lounge area and an adapted bathroom and toilet. The house had an extensive garden.

The service had a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run.

The provider was also the manager of the home. She ran the home with the assistance of a senior support worker who was her daughter-in-law. They both lived in the house with other members of their immediate family. One other person assisted them from time to time and they had a volunteer who helped with some of the domestic tasks. We looked at dependency levels of people in the home and judged that there were suitable staffing levels to meet people's needs.

This service was safe because it had suitable systems in place to ensure that people were protected from harm and abuse. The care team in the home were suitably trained and had information to allow them to report any allegations of abuse.

The home was safe and secure with suitable adaptations to meet the needs of the three people living there. The home was clean and hygienic and there had been no outbreaks of infectious disease. Suitable systems were in place to control infection.

There was a strong person centred and caring culture in the home. Person centred means that care is tailored to meet the needs and aspirations of each person, as an individual. People were supported to lead interesting lives of their choosing, and had a variety of interests, hobbies and were part of the local community.

We saw that people were being treated with dignity, respect and care. There were affectionate and caring relationships between the care staff in the home and the people who lived there. We also saw that other members of the family interacted well with people in the home.

People were encouraged to be as independent as possible. There was no restriction on when people could visit the home. People were able to see their friends and families when they wanted.

People's individual care files contained good assessments of support needs and risk assessments. The care plans were detailed and focussed on each individuals needs and how staff met these and these were regularly reviewed and were up to date.

The staff knew how people communicated and gave people the time they needed to make choices about their lives and to communicate their decisions.

Records showed that systems for recording and managing complaints, safeguarding concerns and incidents and accidents were very well managed and organised.

Staff were experienced in the care of people with learning disability and they kept their practice up to date by attending regular training. The senior support worker had established good local networks with other providers for sharing good practice.

The provider was aware of her responsibilities under the Mental Capacity Act 2005. We made a recommendation that the home looks in more depth about people's capacity to make decisions and how best to record this.

People in the home had regular access to health care. There was evidence of good measures in place to prevent ill health. People received their medications in a safe and timely way from staff who were appropriately trained. Staff were knowledgeable about supporting people in the end stages of their life and had provided sensitive and compassionate support over the years.

The systems in place for monitoring all aspects of care and services were appropriate and effective. There had been no complaints or concerns about the care and services provided and no one on the day had any complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider and staff understood their responsibilities in protecting vulnerable adults.

The house was safe and secure, there had been no accidents or incidents.

The home was suitably staffed and staff had remained stable for more than ten years.

Medicines were managed appropriately and there had been no instances of cross infection.

Is the service effective?

Good

The service was effective.

People received support from staff who had the right training and skills to provide the care they needed.

Support was provided with food and drink appropriate to people's needs and choices in a way that promoted people's health and well-being.

Staff were aware of people's healthcare needs and where appropriate worked with other professionals to promote and improve people's health and well-being.

Staff ensured they obtained people's consent to care. People's rights were protected because the Mental Capacity Act 2005 Code of practice was followed when decisions were made on their behalf.

Is the service caring?

Good

The service was caring.

People were supported in a way that promoted their welfare and well-being.

People made choices about their lives and their independence and dignity were protected and actively promoted by staff in the home. People therefore received support that made a positive difference to their lives.

Staff were knowledgeable about supporting people in the end stages of their life and provided sensitive and compassionate support.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information to staff about people's care needs, their likes, dislikes and preferences. Staff understood the concept of person-centred care and put this into practice when looking after people.

People were also encouraged to pursue their own hobbies or interests.

We saw that accessible information was available to show people how to raise complaints.

Is the service well-led?

Good

The service was well-led.

The provider and staff had developed a strong and visible person centred culture in the service.

There were good community links and mutual exchanges between other local providers for sharing best practice.

The checks on the quality of the service provided were effective for this setting.

Springfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The unannounced inspection was carried out by one adult social care inspector on 10 February 2017.

Before our inspection, we reviewed all the information we held about the home. The information included reports from local authority contract monitoring visits. The manager also supplied us with a range of information, which we reviewed after the visit. We also asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Prior to our visit we had spoken to social workers from the local authority and to staff from the local health commissioning team.

During the inspection we met one person who used the service, the other two were out all day. With the persons permission we spent time with them in their bedroom and looked around the communal areas of the home. We also spoke with the provider, the senior support worker and the volunteer. We also spoke with one visiting social care professional who knew the service well.

We looked at all three care records and the staff training records. We checked the records relating to the management of the service, medication records, and some of the services policies and procedures.

Good

Is the service safe?

Our findings

Some people living in the home had limited verbal communication. One person told us that they were happy and liked the staff. They told us that they felt safe living in this home. We saw that they looked comfortable and relaxed in the home and with the staff who were supporting them.

Social care professionals we spoke with also told us staff were very good at managing risks. One care professional told us, "We have regular meetings to ensure people's needs are being met, and the staff are very knowledgeable. I can't praise them enough."

Care records demonstrated people's personal safety had been assessed and steps were taken to reduce identified risks. Risk management addressed a range of issues associated with each person's care delivery, support outside of the home and their individual vulnerabilities, such as such as using the kitchen, eating and bathing.

Accidents or incidents were reported and documented. Risk assessments were conducted for potential hazards in the environment and the security of the home. Regular checks were carried out of the premises, facilities, equipment, fire safety and infection control to make sure safety was maintained. We observed the home was clean, fresh-smelling and comfortable.

We asked the provider about her arrangements in place for safeguarding the three vulnerable people she cared for. She was able to explain to us how she had managed concerns in the past. She was aware of how to make a safeguarding referral and had good contacts with the local authority. We also saw that there was information about safeguarding available. This meant that anyone on the care team could make a referral if this was necessary. Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The senior carer had designed leaflets for people in the home and other people visiting the home to explain about what safeguarding was.

We found that there was enough staff to meet the needs of the people being cared for at the time of our inspection, and that these were flexibly deployed according to peoples changing needs. The care needs of the three people who lived in the home were met by the provider and her daughter-in-law. The home also had a volunteer who did some domestic tasks around the home. We saw that, at times, one other person who was part of the extended family would deliver care. This was usually when the people in the home went out or when they went on their holidays. We judged that these staffing levels were suitable. There had been no staff recruitment or disciplinary issues in this service for more than 10 years.

All staff and family members and volunteers had a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

We saw that people were safe in their own bedrooms and that the premises provided people with a secure environment. There were contingency plans in place to deal with emergency situations such as fire or power

cuts. For example people had personal evacuation plans which outlined how they would be kept safe in a fire.

There had been no accidents or incidents in the home for many years but we had evidence to show that these would be recorded and reported appropriately. The home needed a more up-to-date accident book and the provider agreed to access one of these. The house was clean and orderly on the day of our visit and there were suitable domestic arrangements in place for infection control.

We checked on the medicines kept in the home. Only two of the three people had any medicine. Medicines given at the home were at a minimum because the local GP had reviewed medicines and reduced these. We saw that these were kept in a locked safe with in a locked cupboard. Medicines were suitably accounted for and the care team were aware of what medication was for. No one in the service had any form of sedative medication.

Good

Is the service effective?

Our findings

People who could speak with us told us that the staff in the home knew the support they needed and provided this at the time they needed it. They told us they got good support and that they were helped to do the things they liked and chose to do. One person told us, "(name senior carer) helps me and we get on great." The people who lived in the home and the Blair family considered themselves as all part of one family. Members of the family who did not deliver care did however, interact with the three people who lived in the home and had responsibilities for things like transport and maintenance in the house.

We looked at the assessed needs and dependency levels of the three people who lived in the home and we judged that these were suitably managed by the two members of the care team. The care team consisted of three people and they had been delivering care for many years. We saw that there were regular two yearly updates to core training. We saw that the team used the skills and knowledge of community nurses, learning disability nurses and other professionals for specific pieces of training. We received positive feedback from healthcare and social care professionals. One health professional told us, "The staff are vigilant at spotting early signs of someone being unwell and we have had good success at getting people early treatment."

Supervision and appraisal in this home was suited to the size of the service. Supervision was done mainly in a group and there were suitable records kept of these group supervision sessions. Appraisal was informal and appropriate to this family business. We saw that the provider's daughter-in-law kept abreast of up-to-date practice by researching on the Internet, accessing training from a local authority home and by networking with other care homes for people with learning disability in the area.

Staff told us that the training they received gave them the skills and knowledge to provide the support people required. For example the senior carer had recently had training in first aid, moving and handling, challenging behaviour, dementia awareness and supporting people who have epilepsy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff applied knowledge of the MCA appropriately. People received care and support from staff who understood how to ensure that support provided was in people's best interest. The staff team had received training on the Mental Capacity Act 2005 and understood their responsibilities if they did consider that they were restricting a person's liberty. The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. The service had followed the legal process when applying for DoLS authorisations to place restrictions on people's freedom. Appropriate plans of care were in place to

ensure that people's care and support needs were met in the least restrictive way.

We found that people's consent to receive care was mentioned in a number of different places within the care plans. However there was only brief mention of people's capacity and the support they required to make decision, such as communication needs and aids. The senior carer had by the end of the inspection arranged to attend a training session on this by using her networks with other local care providers.

During this inspection we identified that the provider had complied with their duties and notified us of all authorised DoLS. However, we recommended that the service looks for good practice methodology in this area so that people's capacity and support needs are assessed and recorded more thoroughly and consistently.

We saw that people in the home had appropriate contact with a consultant psychiatrist for people with learning disability. This had recently led to one person reducing their medications as the home had managed to support this person to become more settled and their behaviours that had been challenging were no longer an issue. The person was now less sedated and were much more animated and able to engage with people and activities.

The provider said that the GP would be consulted if there was a need for psychiatry input but that the local health care providers were good at providing health support. We saw appointments for reviews of health in place and that people had trips out to the dentist, optician and chiropodist. The provider had contact with the specialist learning disability nurses and other nurse specialists. We judged that people in the home had good access to health prevention, care and treatment when necessary.

We saw people having lunch and snacks. All three people looked to be well nourished and there was no restriction on what they wanted to eat. The care team weighed people regularly and no one was underweight. There were simple plans in place for nutritional planning but no one had any special needs in relation to food. One person was being monitored to ensure that they did not gain too much weight and this had been done with support from a dietician. People were given drinks throughout the day and the staff were aware of the need to keep people well hydrated.

People told us that the food was "nice" and they told us about going out to eat. One person who particularly liked fish and chips was taken once a week to a local restaurant. We saw that people regularly ate out and we heard about favourite places to visit.

Springfield house was a farmhouse in a rural location. The three bedrooms, bathroom and lavatory for people in the home were in an extension to this farmhouse. The design and adaptation was suitable for the people in the home. We saw that people were happy in this ground floor accommodation and they were able to tell us that the arrangements in place were to their liking.

Good

Is the service caring?

Our findings

One of three people told us that everyone in the home was "my family" and another person was heard telling the provider that they loved her. Interactions were very affectionate and there was more of a family relationship in the service than might be found in larger establishments. The three people who lived in the service had their own sitting-room but this was never used because they preferred to spend time in the family room and in the kitchen. There was no division between people who use the service and the family.

We observed people were comfortable in the company of staff and the family members living in the home and all responded well when engaging with them. There was a calm, relaxed atmosphere and we saw the staff were kind, friendly and respectful. It was evident there were good supportive relationships. We saw how the senior carer had taken one person to a medical appointment and had been unhappy about the tone and language used about the person by a professional and she had confronted them. She told us, "It was as if the person wasn't there, they spoke very rudely and I wasn't having that. People with a learning disability have the right to respect and treat just like the rest of us."

People were encouraged to be as independent as possible and we observed people helping themselves to snacks in the kitchen, spending time in their own rooms and making their own choices. Care plans placed an emphasis on support to people rather than doing things for them. The language used in daily notes and care plans was appropriate and respectful. One person wishes not to have a daily dairy was recorded and these wishes respected.

We saw staff supported people's self-esteem by assisting them to maintain good standards of personal grooming. People wore clean, co-ordinated clothing and were given support with hairdressing, shaving, manicures and to wear jewellery and accessories. Attention to detail was also reflected in people's care plans.

We saw how people were treated as individuals and their diversity promoted. Each person had a range of their own hobbies and interests. One person had a computer in their bedroom and facilities for streaming lots of different films of their choosing.

People were treated with dignity and respect. Staff were knowledgeable about supporting people in the end stages of their life and provided sensitive and compassionate support. People had advanced statements that staff had completed with them so that their end of life wishes were known in and could be adhered to.

The three people in the home managed most of their personal care and chose their own clothing, times of getting up, food and outings. During our visit we heard people being given information and explanations about choices they would make. People were given options and choices about where to go.

The home had good links with local advocacy services. An advocate is a person who is independent of the home and who supports a person to share their views and wishes. The staff in the home knew how they could support someone to contact the advocacy services if they needed independent support to make or

communicate their own decisions about their lives.

We also saw that confidential files about each person were kept locked away and only accessed by the members of the staff team.

Good

Is the service responsive?

Our findings

During the day there was also a visitor to the home who enjoyed helping out with the horses that the provider kept. One of the people in the home told us that they enjoyed looking after these and did it with this visitor and with members of the family. The home was set in its own extensive grounds which included gardens, stables and a paddock. One person also looked after some pet rabbits and told us they enjoyed spending a lot of time outside.

Each of the three people in the home had their own individual care file. These files included assessments of need, risk assessments and care plans. The files were detailed and up-to-date. They were written in a person centred way and showed people's strengths as well as needs. We saw that were it was appropriate, care plans were in formats to ensure individuals were able to read their own plans and to know what was written about them. People had a file called a person centred plan and these used picture formats and symbols to help people to be involved in setting them up and in deciding how they chose to lead their life and what they liked to do.

Reviews of care plans were carried out regularly and involved the person receiving support. Where necessary their relatives and other health and social care professionals were invited to these reviews.

We spoke to the provider and her daughter-in-law about the care needs of each individual. They understood the life story, family connections and individual preferences of each person very well. They also understood each person's individual care needs. We were told that the night before people had been to "the club". This is one of the ways that the provider helps people to maintain their social networks. This meant that people in the home had contact with other people with learning disability who lived in the area. We were aware that the provider had a lot of local connections and encouraged the three people in the home to continue to be part of this localised social circle.

People in the home went out to a wide range of venues and locations of their choosing. One person enjoyed musicals and live shows and had been to a number recently with staff support. We were told that they all enjoyed going to Sunday markets, car boot sales and steam gatherings. We learned from people in the service that they enjoyed shopping and just generally going out and about.

All three people in the home had been onto holidays in 2016. They had spent 10 days in Yorkshire and had gone to Blackpool to see the lights and go to shows and entertainments. We saw that at the weekends they went further afield into the Lake District or up into the Scottish Borders. One person in the home went to a day centre on a regular basis because they were keen on a number of different activities. We judged that people had suitable outings, access to entertainment and where supported to engage in the local community.

We had not received any concerns or complaints about the service. The provider had not received any complaints but had systems in place for dealing with these. She said that she would speak to individual social workers if there were any complaints so that they could assist with any investigation.

Good

Is the service well-led?

Our findings

People living in the home told us they really liked the provider and staff in the home, referring to them by name, and that they were always willing to spend time chatting and listening to what they had to say. We saw on the visit that people living in the home had an open and friendly relationship with the provider and with the staff team. The provider said, "We are led by the people living here, it's all about what they want to do. We check out all the time that they are happy and try to meet any requests no matter how big or small."

The provider approached the delivery of care as if the people she cared for were members of her family. She told us that her aim was to give people a full life and support them to be as active as possible. People ate together, spent time together and went out and on holiday with members of the family. Her leadership of the service was very much like that of a head of any family.

People told us they made decisions about their lives including planning their own meals and choosing the furnishings and décor for their own rooms. People said they were asked for their views about the home and about the support they received.

We saw that supervision of the staff team was informal because the arrangements in the service were very much based on a family model. We did however see records of supervision and care delivery which showed that there was also a professional aspect to the management of the service.

We also noted that there were records available that gave evidence of management of the environment and simple systems were in place to ensure that Springfield House ran smoothly. We had evidence to show that they regularly asked people in the home about their needs and preferences. We saw that there had been a quality survey where the provider had asked people in the service, their relatives and visiting professionals their opinion. There had been nothing of concern raised in this survey but there had been some minor adjustments made to daily routines and outings because people had told the provider what they did and didn't like.

We were told by the provider that because they had contact with a local authority provider and a private provider of care services for people with learning disabilities they were able to keep up-to-date with practice. They also had a local trainer who came in to update them on any new innovations in practice.

We saw that there were records of things like medicines and money kept on people's behalf. They audited these themselves but also had access to the local pharmacist who would check on their systems and to social services finance officers who audited people's money. We saw evidence to show that these external audits had been done. We checked on money and medicines and found their management to be in order. Records were of a good quality being accurate, up to date and relevant.

There was good partnership working with other agencies to ensure people had access to a full range of services to promote their wellbeing.

We learned from discussions with people who lived in Springfield House that they had a lot of local community networks. The provider and her family knew a lot of people who lived locally and had lots of contacts with people who lived with a learning disability. There was one person with a learning disability who did some voluntary work in the home and we learned that when people went on holiday they went in a group. This group consisted of members of Springfield House's care team, people with learning disability who lived in the community and their relatives. These people knew each other because the provider organised a weekly social club. We judged that there were good community links encouraged by this provider.

Providers of health and social care are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.