

HC-One No.2 Limited

Springfield House

Inspection report

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Date of inspection visit:
21 January 2022
24 January 2022

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Springfield House is a residential care home providing personal care to up to 69 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 44 people using the service.

People's experience of using this service and what we found

The service did not always manage medicines safely. Appropriate documentation for 'as and when' medicines and topical medicines were not in place; some medicines were not stored correctly. This meant people may not have received medicines at the right time, or may have received out of date medicine. Since the inspection the management team have improved the documentation.

Visitors' COVID-19 tests and vaccination status (for professionals) were not checked on arrival. Deep cleaning was not being carried out due to staff shortages. This put people at risk of catching infections.

There were not enough staff on duty to safely care for the needs of people living at the service. Some non-care staff were helping with caring duties, and not carrying out their own duties which were also important, such as activities. Since the inspection staffing has been increased.

Quality assurance checks were not always effective meaning a number of issues had been missed in relation to medicines management, staffing and care records.

Care records were not always in line with best practice guidance as some information was not consistent. We have made a recommendation about reviewing care records.

The management team were working to develop a more open culture at the service. Staff felt able to approach the manager for help or to raise issues.

Systems and processes were in place to safeguard people from the risk of abuse. Accidents and incidents were investigated, and staff had learned lessons from things going wrong. Risk assessments were in place, the building was well maintained, and regular safety checks were carried out.

Staff were trained appropriately and recruited safely. Staff told us that the manager was supporting them to improve their skills.

People were supported to maintain a balanced diet and people were supported with specialist diets. Staff worked with other agencies to ensure people had access to the right care and support. The service was adapted to suit people's needs and there were regular opportunities for people and their relatives to give feedback.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The last rating for this service was good (published 27 November 2017)

Why we inspected

We undertook a targeted inspection due to information we had received about the service including an outbreak of COVID-19 and the visiting processes.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

The inspection was expanded due to concerns about staffing levels.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of the full report.

You can see what action we have asked the provider to take at the end of the full report. The provider has already taken steps to mitigate the risks which we have taken into account.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Springfield House on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management of medicines, infection control, staffing levels and quality assurance checks.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Springfield House

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection team consisted of three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Springfield House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Springfield house is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service's registered manager had just left the service and was deregistering with CQC. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 21 January 2022 and ended on 24 January 2022. We visited the service on 21 and 24 January 2022.

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What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with two people who used the service during the visit, and five relatives of people who used the service by telephone. We observed staff interactions with people; and spoke with nine staff members including care staff, senior care staff, wellbeing coordinator, housekeeper, laundry staff, the acting manager, area director and managing director during the site visit and by telephone.

We reviewed a range of records including multiple care and medicine records. We looked at two staff files in relation to recruitment; staff supervision and training records. A variety of records relating to the management and quality assurance of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. The provider sent

additional information to evidence action they had taken following feedback from the inspection. We informed the local authority of our findings who have been supporting the manager to improve care plans and medicine management.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely. Documentation for 'as and when required' medicine was not in line with best practice guidance. It did not include key information such as symptoms to look out for, outcomes to expect or follow up information such as reporting repeated use to the person's GP. This meant staff may not know when to give people their medicine or whether the medicine was effective.
- Records did not show where on people's bodies medicine patches had been placed. Some patches must not be placed in the same place for a set amount of time; there was a risk of this happening. Care plans did not include sufficient detail about why people took each medicine or how they preferred to take their medicine.
- Some medicines were not stored correctly. Opening dates had not been written on some liquid medicine. This put people at risk of receiving out of date medicine that may not be as effective..
- Recent medicines audits had not identified the concerns that were found during the inspection.

The failure to have an effective system in place to manage medicines safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the management team had put in place new 'as and when required' medicine documentation which meets best practice guidance. They were also exploring the use of body maps in their electronic medicines system to support people who receive medicine patches.

Preventing and controlling infection

- The process for visitors entering the service was not always safe. Visiting professionals were not always asked to provide proof of their COVID-19 vaccination status or of a negative COVID-19 test before entering the building. A relative also said they were not asked for proof of a negative COVID-19 test when visiting. This meant people were at risk of infection from visitors.
- There were not enough housekeeping staff to keep the service clean. Staff were diverted from cleaning duties to support people due to a lack of care staff. Records showed that deep cleaning of rooms was not taking place, but general cleaning of communal areas and rooms was being completed.

The failure to carry out checks on visitors and maintain cleanliness during a COVID-19 outbreak was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was meeting shielding and social distancing rules.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

- The service did not always have enough staff on duty to care for people safely. A dependency tool was used to calculate staffing requirements, however there were numerous occasions where staffing dropped below the required number. Managers, housekeeping, and wellbeing staff were supporting care staff at times of low staffing. The non-care staff were trained to provide support, but they were unable to fulfil their own roles while supporting with care.
- One person said, "[The staff] are busy, you can't stop them, they only talk to me if they're helping me". A relative said, "Staffing levels are very tight, they are busy all the time and have no time to sit and chat to [person]." Another relative said "There are not enough staff, [person] often has to wait to go to the toilet."
- Staff said that there was frequently only one member of staff on the Grace Unit, which had nine people living there at the time of the inspection. Some people required two members of staff to support them, so they had to use staff from other units when those people required support.
- The dependency tool indicated that additional time should be allocated when there were people with COVID-19, which had not been taken in to account. There was no time allocated for care planning and document review.

The failure to have sufficient numbers of staff on duty was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the management team increased staffing at the service. Staff confirmed that the staffing had increased.
- Staff were recruited safely. Employment checks were carried out in line with best practice guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were in place to safeguard people from the risk of abuse. Incidents and accidents were investigated thoroughly, and records showed lessons were learnt. Regular reviews to look at trends in falls took place and actions were identified to help minimise the risk of falls.
- Staff were aware of how to report safeguarding and whistleblowing concerns. Lessons learnt were shared with staff during regular meetings.
- One relative said, "[Person] is very safe, she is prone to falls and they have placed a sensor mat beside her bed, if I tread on it by mistake a carer is always there quickly to check on [person]."

Assessing risk, safety monitoring and management

- Risks to people's safety were assessed. Risk assessments were in place for key areas such as falls, moving around the service, choking, eating and drinking. The assessments were regularly reviewed and updated when people's needs changed. However, there were no risk assessments in place for emollient creams, we raised this with the manager who took action to put these assessments in place immediately.
- The service was well maintained. Documents showed regular checks to safety equipment in line with best practice. Maintenance staff knew what checks needed to be carried out and how to deal with any identified problems.

Visiting in care homes

- The provider was facilitating visits in line with government guidance. At the time of the inspection there was an outbreak of COVID-19 meaning visiting was limited. People were supported to have essential carers who were able to visit during outbreaks.
- There was a visiting pod which allowed visits in a private area away from other people. Some people were having 'in-room' visits in line with guidance.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

- The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Some care plans were not in line with best practice for mental capacity. The records showed people did not have capacity to make their own decisions, but they were being asked for consent. Some people had DoLS in place which had expired.
- The provider had carried out mental capacity assessments and best interests decisions for people who lacked the mental capacity to make some decisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;

- Care plans were not always person centred. Some information in care records was not consistent, for example, one part of a person's record referred to high risk of choking and a separate section referred to low risk of choking. This put people at risk of receiving the incorrect level of support.
- One record identified a person was a low dependency level, but other parts of the care plan showed they had a higher dependency level. The lower level was used to plan staffing. We raised this with the management team who reviewed all dependency levels.
- People or their relatives or advocates were involved in the care planning process.

We recommend the provider reviews all care records including medicines and risk assessments and ensures they are person-centred. The provider gave assurances that this will be addressed following the inspection.

Staff support: induction, training, skills and experience

- Staff were appropriately trained. New staff received a detailed induction and regular refresher training was carried out for all staff. One staff member said they were unsure about the new electronic medicine system but the manager was supporting them and they were now ready to progress their career upwards.
- Staff knew the people they cared for. One relative said, "Even though [person] has dementia she recognises the staff and they are affectionate to her."

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain a healthy diet. People met their daily targets for fluid and food intake. Some people required specific diets which were catered for.
- A relative said, "[Person] was underweight and were put on a high calorie diet, they have gained weight and the home are always offering her snacks." Another relative said, "[Person] is blind, when the staff bring her food they explain where the meat and veg is like a clock so she knows exactly where it is on her plate."

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

- The management team worked effectively with other agencies. People were referred to services such as occupational therapy and the speech and language therapist in a timely manner.
- A relative said, "When mum came out of hospital after a stroke, I gave the senior the discharge letter and they got in touch with the Stroke Association and the GP, it was followed up really well."

Adapting service, design, decoration to meet people's needs

- People's rooms and the communal areas were decorated to a good standard. All areas of the service were accessible to people including the garden. The Grace unit had dementia friendly decoration.
- Resident meetings were held to give people a voice in the way the service was run. For example, people had a say in how the service was decorated for Christmas and what activities they would like.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance checks did not always identify issues. There were a number of inconsistencies identified during the inspection in care records and medicine management that had not been identified in management quality assurance checks.
- Seven months before the inspection the service received feedback from the local authority commissioning team which identified similar issues in medicines management. No action had been taken to address those issues.
- The dependency tool used to calculate staffing levels was not regularly refreshed and did not capture key data such as the number of people with COVID-19.

The provider's failure to ensure effective quality monitoring systems were in place was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were clear about their roles, however due to staff shortages they were required to support in other roles. The deputy home manager was new to their role and was being supported by regional management.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; continuous learning and improving care

- Feedback about the culture was mixed. The management team were working on improving the service culture. Staff indicated that they had felt the regional management were distant and not approachable, but recently this had changed. Managers explained they were taking action to improve this.
- Staff said they felt able to approach the manager and were supported by them.
- Most people and relatives spoke positively about the service and the care and support they received. A relative said, "I am really happy with the level of care, they do a really good job and are very caring. They create relationships with residents. [Person] has been better health wise since she has been living there."
- The area director made regular visits to the service and there was an action plan in place to continually improve the service. Many of these actions related to the look of the service and health and safety of the environment.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

- People using the service were given opportunities to give their views on all aspects of their care and support. People and their relatives were involved in care plan reviews; the latest reviews had been carried out via telephone due to a COVID-19 outbreak in the service.
- Events were held for special occasions. During the inspection a special 'Burn's Night' lunch was being served. One relative said, "On Valentine's Day I was invited to a Valentine's tea, we all had roses and the tables were laid beautifully."

Working in partnership with others

- The manager and staff worked effectively with others. Staff involved external professionals when needed, for example, referring people for support with pressure area care and speech and language therapy.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Management understood the duty of candour and the need to be open and honest. The registered manager had reported incidents to CQC and other stakeholders where appropriate.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(g)(h) HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure medicines were safely managed, checks to ensure visitors were free from COVID-19 were not always carried out, and deep cleaning was not being carried out during a COVID-19 outbreak
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a) HSCA RA Regulations 2014 Good governance The provider failed to ensure appropriate and effective quality assurance systems were in place to ensure the safe and effective running of the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient staff were on duty.