Springfield Manor UK Limited

Springfield Manor 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Springfield Manor is a nursing home providing personal and nursing care for up to 30 older people, some of whom were living with dementia. The home is a large adapted building. At the time of the inspection there were 25 people living at the service.

People's experience of using this service and what we found
People were not always adequately protected from infection. We found areas of the service to be unclean with bins that had not been emptied and inadequate cleaning carried out in the communal shower areas. When people visited the home during the COVID-19 pandemic, a robust procedure to reduce the spread of infection was not always followed.

Risks to people were not always managed safely. Where risks associated with people's care had been identified, this was not always clearly and accurately documented in their care plan. Staff did not always have awareness of risks to people and how to support them.

Although audits were taking place, these were not always effective in identifying shortfalls at the service. There was no formal system in place to gain feedback from people, relatives and staff.

There were sufficient staff to meet people's needs, however, the deployment of staff meant that they did not always have time to spend with people. We have made a recommendation about this.

People told us they felt safe living at the service. Staff had received training in safeguarding and knew how to report a concern. People's medicines were safely managed. People receive their medicines on time and were closely monitored for any changes in health.

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 1 September 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to check whether the requirement notices we previously served in relation to Regulations 12,13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also continued to receive feedback from external professionals around the lack of robust management of the service. These related to protecting people from abuse, assessing risks to people and lack of management oversight. The overall rating for the service has not changed following this focused inspection and remains Requires Improvement.

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 coronavirus and other infection outbreaks effectively.

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

Enforcement
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 to get assurances about people's safety.

We have identified continued breaches in relation to infection control practices and the lack of robust auditing. Please see the action we have told the provider to take at the end of this report.

Follow up
We will write to the provider to request information about how they will make changes to ensure they meet the requirements of the Regulations and improve their rating to at least good. We will meet with the provider following this report being published to discuss their improvement plans. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Springfield Manor Nursing Home

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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. 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
Our inspection was completed by two inspectors.

Service and service type
Springfield Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are 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.

What we did before inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection-
We spoke with five people who used the service about their experience of the care provided. We spoke with six members of staff including the provider and registered manager.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at two staff files in relation to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We spoke with two relatives about their experience of the care provided.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

● Individual risks to people were not always being managed in a safe way. For example, one person was at risk of malnutrition and had been consistently losing weight. The person was on a food and fluid chart and although there was a target and total amount recorded for fluid intake, this was not happening with their food intake. Instead the care plan stated the person was eating the whole meal or part of the meal but no detail of what these amounts were. The person was still losing weight. One relative told us, "The care review is lacking."
● Another person was living with dementia and was at high risk of falls and spent a lot of their time walking around the home. The person lived on the top floor and their care plan stated they were at a high risk of falls. During our inspection on the first day, we found the door on the top floor leading to the stairs to be unlocked, which posed a risk to the person due to their dementia.
● We had been notified by the registered manager of an incident where a person had left the building unaccompanied when they were not safe to do so. This risk of this was recorded in the person's care plan with a risk management in place. However, when speaking to a member of staff about this risk, they were unable to identify the risk to the person or what needed to be done to reduce this risk. Staff told us they did not read people's care plans and were not always familiar with the risks around people's care.
● We were not assured the provider was promoting safety through effective hygiene practices. We observed both sluice rooms to be untidy with no evidence of the sinks being used due to a build-up of limescale. Staff told us they used the sluice rooms to clean commodes, however, staff confirmed that hand hygiene was not performed in the sinks in the room after carrying out this activity. One relative said, "The public areas are usually clean, (the person's) bedrooms not so much. A little unhygienic if (the person) had accidents, it doesn't smell too fresh, there have been issues with that.
● We were not assured the provider was preventing visitors from catching and spreading infections. On the first day of inspection when entering the home our temperatures were taken and we were wearing masks. We performed hand hygiene and had the knowledge that we had not been displaying any symptoms of COVID-19, however, this was not asked of us by staff at the service despite the registered manager telling us this should have been done.

● Accident and incidents were recorded with actions recorded to reduce further risks. However, we reviewed the analysis of incidents for November 2020. There was no information on whether falls which had occurred were witnessed and whether staff deployment needed to be considered to reduce the falls.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued 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.

Staffing and recruitment
● We received mixed views from people about the staffing levels in the service. One person said, "I am never left without someone coming to see to my needs. If I use the call bell, I don't wait very often." However, another person said "My basic needs are met but I feel isolated, I never get to chat to anyone"
● Staff felt that staffing levels had improved since the last inspection. A staff member told us "Now that's an improvement, we have enough staff to look after the residents. We don't book agency. After personal care we chat to people."
● We observed people who sat in the communal areas were supported by staff who frequently checked on them and engaged them in activities. However, people spending long periods of time in their bedrooms had little interaction from staff members who were busy providing care to others. One person told us, "I am very aware I am one of the only people without dementia here, sometimes it takes 20 minutes for my call bell to be answered". We raised this with the provider who told us they would take steps to address this.
● We asked the registered manager if they undertook call bell audits to check how soon call bells were responded to. They told us they had not been undertaken recently but would take action to address this.
● There had been no staff had been recruited at the service since the last inspection, so we did not review recruitment files. There were no concerns when we checked recruitment at the last inspection.

At our last inspection the provider had failed to robustly protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe at the service, comments included, "I never worry about how staff would treat me. They are very kind", and "Staff are nice people." We observed kind and caring interaction from staff with people.
● Staff told us that they had received safeguarding training and understood what constituted abuse or neglect. One staff member told us, "It's protecting people from harm. If I saw anything, I would inform the nurse, if not then go to the manager. Then I record it. If it was the manager, then I would report to CQC."
● The service had a policy to inform staff what they needed to do in the event of a safeguarding concern, however, not all staff knew where to find this policy or who to contact outside of the organisation if they had a concern. We asked the registered manager if they could address this with staff, they confirmed they would do.

Using medicines safely

● The management of medicines was safe and organised. Medicine trolleys were in place for each area of the service with clear sections for each person's medicines. There was a front-page profile on people's Medication Administration Record (MAR) with a photograph to aid identification, a list of allergies and details of the person's GP. Medicines were given on time and there were no gaps in administration.

● There were individual protocols for specific medicines that were only required when people were experiencing symptoms. These were personalised to the individual person and medicine, so staff knew how and when to administer the medicines.

● People with diabetes were closely monitored and had an individual record kept for their blood sugar levels and insulin administered. People had individual boxes with their equipment to manage their diabetes.

● Staff had good knowledge of people's medicines. One person liked to take their medicines with porridge and the nurse knew about this and it was documented in the person's MAR.

Requires Improvement

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

At the previous inspection we found that there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● At the previous inspection we identified that the auditing and governance was not robust which meant that the quality of care was not reviewed appropriately. Whilst there had been some improvements, these were not consistent. We continued to find shortfalls that had not been picked up by audits that were taking place by the provider or registered manager.
● There were insufficient systems in place to robustly check the quality of care. We identified concerns with the cleanliness of the environment and the infection control practices which had not been picked up through any health and safety audit and infection control audits. Call bell audits were not taking place despite, according to a staff meeting in September 2020, a concern being raised about the functionality of the call bells.
● Care plans continued to have out of date and conflicting information around people's needs despite the provider undertaking care plan audits. For example, one care plan stated the person had no concerns with their eating and drinking. However, the person had been losing weight which was being monitored by staff. Another person had fallen however their care plan stated they were not at risk of falls.
● People told us they did not feel the registered manager was always accessible. Comments included, "I think she does quite well, but she is of late very, very busy. I don't see her as much as I would like to" and, "I don't see her much, would like to see her more."
● Formal systems were not in place to gain feedback from people about their care. Although a residents' meeting had taken place, this took place in August 2020 and was limited to feedback on the food. One person said, "They (staff) rely on me actively telling them when I am not happy with something. I couldn't recall the last one (meeting) we had." Surveys for people and relatives were not taking place despite this being raised as a concern at the previous inspection. We received feedback from people that they felt isolated in their rooms which could have been addressed if the provider had asked for feedback from them.

● Relatives fed back that communication from the registered manager and staff could be improved upon. One relative said, "We only get contacted if they have a case of the virus. They could give us a bit more feedback. (The staff) don't tell me when he loses weight or generally how he is doing."
● Staff told us the management of the home had improved. One member of staff said, "She (the registered manager) is supportive to us." However there remained a lack of systems in place to gain feedback from staff and to involve them in the running of the home. The last general staff meeting took place in September 2020 to discuss all aspects of the service. Since then the only meeting that had taken place was to remind staff of their responsibilities around infection control.

The shortfalls in relation to the leadership and governance of the service were a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection there had been some improvements with the auditing of care. Senior staff recorded regular discussions about people's clinical needs to include wound care, weight loss and falls. Medicine audits took place and where shortfalls had been identified steps were taken to address this.
● The provider had taken steps to appoint a clinical lead. Their responsibility was to have oversight of people's clinical needs. They were to have one to one clinical discussion with the nurses and we saw this was taking place.

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; Working in partnership with others

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Since the last inspection the registered manager had informed the CQC of significant events including incidents of injuries and safeguarding concerns.
● The provider and registered manager worked with external organisations that regularly supported the service. The registered manager told us the CCG had assisted the service with implementing new documentation relating to the hydration monitoring for people.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks associated with people's care was being managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that leadership and systems and processes were established and operated effectively