Horizon Care Springfield Limited

Springfield Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Springfield Grange is a nursing providing personal and nursing care to 43 people aged 65 and over at the time of the inspection. The service can support up to 94 people.

Springfield Grange is a purpose built home, split over four floors and comprising five individual units. At the time of the inspection only four of the units were operational. The homes offers both nursing and residential care. One of the units provides care and support to people living with dementia.

People's experience of using this service and what we found
People were not adequately protected from avoidable harm. Care records did not provide sufficient detail and the premises and equipment were not always clean. Staff were not complying with good practice guidance when using face masks. There were enough staff employed and there were processes in place to recruit staff. Medicines were administered safely..

Systems of governance had failed to ensure the service continually improved. This was clearly evidenced by a failure to ensure the home was clean and hygienic. Audits were completed but were not easy to understand. There were opportunities for people who lived at the home, and staff to engage with the registered manager and senior management team.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 28 February 2020) and there were multiple breaches of regulation. At this inspection we found although some improvements had been made the provider was still in breach of two regulations.

Why we inspected
We received concerns in relation to staffing, infection prevention and control and management oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has not changed and remains, inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Springfield Grange 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 and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and governance.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Springfield Grange

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.

Inspection team
The inspection team consisted of three inspectors.

Service and service type
Springfield Grange 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
We telephoned the registered manager on the morning of the inspection to announce the inspection. This was due to the Covid-19 pandemic to ensure we had prior information to promote safety.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning, continuing care, safeguarding teams and community nurse teams. We also spoke with eight members of staff on the telephone, this comprised nurses, nurse assistants, care workers and ancillary staff. 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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke, briefly, with two people who used the service. We spoke with 10 members of staff including the registered manager, nominated individual, regional quality manager, three nurses and four staff from the care and ancillary teams. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and a random sample of medication records. We also looked at a variety of records relating to the management of the service, including audits and action plans.

After the inspection
We requested further information from the registered manager and senior management team to validate the evidence found. This was received, and the information was used as part of our inspection. Following the inspection, we also, at the request of the senior management team, had a virtual meeting with the nominated individual to review their systems of governance and auditing.

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 inadequate. At this inspection this key question has now improved 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.

Assessing risk, safety monitoring and management

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.

Enough improvement had not been made and the provider is still in breach of regulation 12.

• People were not adequately protected from avoidable harm. One person was identified as being at high risk of falls. They wore a helmet to minimise risk of head injury. We saw the helmet was not fitted correctly as the crown of the person's head was visible. We asked a member of staff why the helmet was not fitted correctly, they told us, "We have lost the string to hold it in place". We also observed this person walking along the corridor, bent over, wearing only one sock which was loosely falling off their foot. This was an additional factor which may increase the risk of them falling.
• Care records did not provide sufficient detail to protect people from the risk of serious harm. The care records for one person noted, 'There is a risk that [name of person] could enter the other residents' bedrooms'. Daily care notes dated 22 June 2020, recorded them being unsettled and going to other people's rooms and waking them up. There was no specific plan of action for staff to follow to prevent this person entering other people's bedrooms or what tactics staff should deploy in the event they entered another person's room.
• Moving and handling care plans and risk assessments did not provide sufficient detail to protect people from the risk of serious harm. We reviewed the moving and handling care plan and mobility risk assessment for two people who required the use of a hoist and sling. There was no detail recorded as to which hoist was to be used or how the sling should be applied or fitted.

We found no evidence that people had been harmed however, there had been a failure to ensure the risks to the health and safety of people were robustly assessed and acted upon. 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.

• On the first day of the inspection we observed multiple examples of staff poor practice in the use of fluid resistant face masks. For example, the registered manager was not wearing their mask securely and they were frequently touching and adjusting the mask. We also saw some staff wearing their face masks under their noses and removing them to take a drink and not replacing them.

• The premises and equipment were not always clean. For example, one person had their feet elevated on two cushions. One of the cushions did not have a washable cover and was just foam. The foam had unknown debris and hair stuck to it. In another person's room we saw a sensor mat was unclean and the assistance seat in the en-suite bathroom had faeces on it.
• On the first day of the inspection we observed five people who were in their bedrooms. Each person had a jug of juice in their rooms. None of the jugs had a lid. One person had a cantilever table at the side of them. On the table was a jug of juice, without a lid and next to it was a full urinal bottle.
• On the second day of the inspection, in the communal lounge/dining room on one of the units we lifted one of the seat cushions of an easy chair. The base was visibly stained. The netting from the cushion was noted to be hanging out of the cover by the zip. The netting was stained brown. We also saw the zip of a pressure cushion in a bedroom was stained and when we opened the zip, the inside cover was also stained. In their en-suite bathroom there were faecal stains on the shower seat.
• Cleaning records were incomplete. For example, the name of the unit was not recorded and dates were missing. A form to record the regular cleaning of frequent touch points, less than a quarter of the check boxes had been completed.

We found no evidence that people had been harmed however, this evidenced a failure to do all that is reasonably practicable to ensure the premises and equipment are clean, thus reducing the risk of infection and control the spread of infection, to service users or staff. 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.□

Staffing and recruitment
At our last inspection the provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of regulation 18 (Staffing) 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 18.

• There were enough staff employed daily to ensure people's needs were met. Where shortfalls in staffing were identified, agency staff were assigned.
• Seven of the eight staff we spoke with were satisfied with the staffing levels at the home.
• One person who lived at the home told us staff responded when they pressed the nurse call and although their response time varied, they did not feel it was unreasonable.
• The registered provider had systems in place to reduce the risk of employing candidates who may be unsuitable to work with vulnerable adults.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and 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 12.

• Medicines were stored safely
• Medicines were only administered by staff who had received appropriate training and an assessment of

their competency had been completed.
• There were systems and processes in place to ensure people received the correct medication in a safe and timely manner.

Systems and processes to safeguard people from the risk of abuse
• There were systems and processes in place to protect people from the risk of harm or abuse.
• Staff received regular safeguarding training.
• The registered manager was aware of how to escalate any safeguarding concerns to the local authority safeguarding team.

Learning lessons when things go wrong
• There were systems in place to ensure accidents and incidents were recorded and reviewed. The registered manager told us the regional quality manager completed a weekly analysis to ensure opportunities to reduce future risks were identified.
• The nominated individual, regional quality manager and registered manager all verbalised an open and transparent attitude towards learning lessons when things went wrong. However, as is clearly evidenced within this report, further work is needed to ensure that learning and changes to practice relating to people's care and support are embedded within all the staff team.

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively. The provider had not assessed, monitored and improved the quality and safety of the service provided or taken appropriate action to mitigate risk. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made and the provider is still in breach of regulation 17.

• Systems and processes of governance were inadequate. This was clearly evidenced by the registered provider and registered manager's failure to ensure the premises and equipment were clean and hygienic.

• During a phone call with the senior management team and the registered manager on 5 June, the registered manager told us they had worked with the domestic staff to ensure they knew how to clean a room. The findings in the safe section of this report evidence this had not been effective. The registered manager also told us observations had been completed of staff practice in putting on and removing personal protective equipment (PPE). The documents we were shown on inspection evidenced a supervision had taken place but did not evidence an observation of practice had been completed.
• A senior nurse from the local authority infection prevention and control (IPC) team visited the home on 16 June and 22 July 2020. Despite their feedback to the registered provider and registered manager, and feedback from our visit on 25 June 2020, we still identified significant failings in cleanliness and infection control practices when we visited on 28 July 2020.

• An infection control audit, dated 27 May 2020, completed by the registered manager scored 94.68%. A further infection control audit, dated 29 Jun 2020, scored 96.84%. The audits were not suitably robust as they had failed to identify or address all the issues with hygiene and infection control practices noted by both the IPC nurse and ourselves.

• The system used by the registered provider to complete audits was not easy to follow. For example, the infection control audit, dated 27 May 2020, one section noted '17 failed, 93.5%', another section noted '1 failed, 100%'. We also reviewed two audits, December 2019 and February 2020, completed by the regional quality manager. Despite both audits scoring in excess of 90%, there were over 30 failed items and action

points on each audit.

We found no evidence that people had been harmed however, systems and processes were not operated effectively to ensure the service continuously improved. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The senior management team and the registered manager were highly visible within the home.

• The registered provider employed staff with specific responsibilities to support the registered manager. For example, staff training and safeguarding.

• Many of the systems used by the registered provider were electronic. For example, care plans and medication records. This enabled the registered manager to be able to monitor and review this information in a timely manner.

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

At our last inspection the provider had failed to comply with their legal requirement to notify us specific incidents. This was a breach of regulation 18 of the CQC (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 of the CQC (Registration) Regulations 2009.

• We did not identify any incidents which the registered provider or registered manager had failed to notify us about.

• Notifications had been submitted to CQC in a timely manner.

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

• Most of the staff we spoke with told us they felt supported by the management team. One of the staff told us, "I am enjoying working [here], I like the staff and the people." Another staff member said, "Yes, it is a happy place."

• The most recent staff meeting had been held in March 2020. As a result of the coronavirus pandemic, the restrictions on gatherings and the need for social distancing, these had ceased. The registered provider told us staff had been provided with other opportunities for engagement, including drop in sessions and weekly telephone call to check wellbeing for those unable to work. Themed staff surveys had been completed in March and June 2020.

• Formal meetings with people who lived at the home had not been able to take place since March. One of the staff we spoke with assured us any concerns raised by people who lived at the home would be listened to and addressed.

• Our discussions with the management team and staff along with our review of records demonstrated that

discrimination was not a feature of the service and people were not treated unfairly because of any characteristics that are protected under legislation.

Working in partnership with others

• The registered manager and management team were working with other agencies, including the local authority to address the shortfalls identified within the home.

• The registered manager had worked with the local commissioning bodies to provide care and support for people discharged from hospital, including those affected by the coronavirus pandemic.

• Links within the local community, for example the local church, had been put on hold in recent months as a result of the government restrictions due to the current pandemic.

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 17 HSCA RA Regulations 2014 Good governance The registered provider and registered manager had failed to ensure had failed to ensure systems and processes were established and operated effectively to ensure the service continually improved.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There had been a failure to do all that was mitigate the risk of harm to people. There had been a failure to ensure the premises and equipment were clean and hygienic.

The enforcement action we took:

We served a Warning Notice on the Registered Provider and the Registered Manager.