Springfield Park Care Home Limited

Springfield Park Nursing Home

Inspection report

Springfield Park
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Springfield Nursing home is a care home which can accommodate up to 70 people over two floors.

People's experience of using this service:
Our inspection identified a number of areas of concern in the home. Moving and handling was not always safe, and assessment and management of risks was not always robust. Staffing levels were not well managed, and we found staff did not always know what people's needs were or how to support them safely. There was a good level of staff training in place, however our observations showed this was not always followed. Staff were recruited safely and had regular support from senior staff and management.

People were not always supported appropriately when they lacked capacity to make decision, and consent for some aspects of care and support was not always sought robustly. Information about this aspect of people's care and support was not well organised. People's privacy and dignity were not always maintained.

Records relating to people's nutritional health were not always well maintained, and there was a lack of robust information about how to thicken fluids when this was required. People who required a diet adapted to their faith or cultural background received this. The provider produced information in adapted formats to help people access it independently.

People did not always have control over their daily lives and routine, and there was a lack of stimulus in the upstairs unit. People knew how to make complaints, however we saw the provider's policy was not always followed and people did not always receive a written response when they had raised concerns. There had been some good support put in place when people had died, but care plans lacked information about people's wishes and preferences for this aspect of their care.

Although there were systems in place to monitor quality in the home, they were not sufficiently robust, and had failed to identify areas in which regulations had been breached.
Rating at last inspection: This was our first inspection since its change of provider.

Why we inspected: We carried out this inspection in line with our current inspection planning methodology.

Enforcement: We have identified breaches in relation to the safety of care and treatment, regard for people's dignity, support for people who may lack capacity to make certain decisions, staffing levels and the overall governance of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore 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.

Follow up: We will re-inspect the service inline with our current inspection planning methodology. We may return sooner if we become aware of increased risk to people who use the service.

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

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 safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in the Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in the Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well led.

Details are in our Well-led findings below.

Inadequate

Springfield Park 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
On the first day of our inspection the team consisted of three inspectors, a specialist advisor in nursing and an expert-by-experience with a background in caring for someone who used this type of service. On the second day two inspectors attended.

Service and service type: Springfield Park Nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual arrangement. 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:
Both days of our inspection were unannounced.

What we did:
Before the inspection we reviewed all the information we held about the service, including notifications about events and incidents the provider is legally obliged to send us. We had not sent a provider information

return request (PIR) before this inspection. This is a request for information about what the service does well and what the provider plans to do to ensure the service continues to improve.

During the inspection we spoke with the registered manager, the area manager and the deputy manager. We also spoke with 12 staff, 15 people who used the service and four visiting friends and relatives.

We spent time making observations in all communal areas of the home and visited some people in their rooms with their consent. We looked at documentation relating to the running of the home including ten people's care plans and associated medicines records.

Inadequate

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

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

- Our observations highlighted concerns about staff practice. We saw instances of 'drag' lifting. This is any method of handling where staff place hands or arms under the person's armpit. Use of this technique can result in injury to the person including dislocated joints, fractured bones, ruptured ligaments, and skin tears. It can also cause pain and discomfort to the person.
- One person's feet did not safely reach the footplates on their wheelchair, and we saw a staff member had placed a scatter cushion under their feet. This was not fixed in place and we saw the person's feet were slipping. When we asked the member of staff why this cushion was in place they told us it was a 'special' cushion.
- We saw staff attempt to transfer someone from their wheelchair using a hoist and sling. One member of staff said, "I don't like this sling" and asked for another. When we asked, which was the correctly sized sling to ensure the person's safety they did not know, and told us "This one, apparently." There was no information in the person's care plan to show which sling should be used to ensure it was the correct size and unique to the person.
- Assessments of risk were not always robust. We saw a number of calculations of people's level of nutritional risk were incomplete and did not indicate the level of risk. On the first day of our inspection we were told by staff that three people on the upstairs unit were at risk from poor nutritional intake. None of the three people had nutritional risks highlighted in their care plans. One person had a risk assessment which scored their nutritional risk as '11', but there was nothing to explain to staff what this may mean or what action they should take to help the person manage this risk.
- Two staff were observed on the upstairs unit making a thickened drink for a person. When we asked how they knew how much thickener was needed to make the drink safe, neither could tell us.
- The care plan for one person who experienced behaviours which challenged them and others stated that staff should make formal records of any incidents, using 'ABC' charts. An ABC chart is an observational tool that allows us staff to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating. We saw staff recorded diary notes about incidents, although these focused on the impact on staff rather than the person concerned, and contained no information, which may have helped identify the causes and reduce the frequency of incidents.

Using medicines safely

● We saw in the regional manager's audit of the service they had picked up staff were not recording when creams and ointments were administered, and we found these records were now in place. However, they were not always completed every day, meaning we could not tell whether people always had their creams and ointments applied. Some gaps and errors were also seen on the medicines administration records (MARs) for other medicines.

● There was an inconsistent approach to the recording of administration of 'as required' (PRN) medicines. The therapeutic effect of medicines given in this way was not always recorded, and we saw there was an inconsistent approach to providing guidance to help staff when a variable dose could be given.

● Staff could not tell us whether the temperature of the medicines storage room on the upper floor was monitored, and we could not see any evidence of a thermometer or records in the room. This meant medicines could have been stored at a temperature which may have had an impact on their effectiveness.

The above evidence shows the provider is in breach of regulation 12, Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular checks were in place to ensure the safety and regular maintenance of equipment and fittings.

Staffing and recruitment

●Staff deployment in the home was chaotic and did not resemble the planned levels described to us by the registered manager. On the first day of our inspection we were told three care staff were deployed on the upper floor, however we found only one senior care assistant and a person on the second day of their induction. When we asked staff on the upper floor about people and their care needs, we were often told they did not know these as they were not meant to be working upstairs. They did not know why they had been asked to support people on that unit and told us they did not know their needs.

● Staff feedback about staffing levels was varied. Nursing staff in particular expressed concerns at their ability to provide the care people needed. One member of staff told us, "There are just not enough nurses here to meet the needs of these people." Another member of staff told us the delivery of care was timed in relation to staff availability rather than in line with people's needs and preferences.

● People we spoke with gave mixed feedback about their experiences of staffing levels. Some people felt they received a good response to their needs, others told us they had to wait. Relatives were more consistently negative about the numbers of staff. One relative said, "I am concerned at night time, only one staff member for upstairs residents." Another relative told us, "[Name of person]'s needs have changed over the years, and they need more support and care for staff. Staff ratio should have increased but it hasn't."

The above evidence showed the provider was in breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they had a tool to work out how many staff were needed but said it was not robust enough and had not been updated for some time. We did not see an assessment of the level of dependency in people's care plans. This meant there was no formal process in place to ensure the staffing levels were sufficient to meet people's needs. On the second day of our inspection the deputy manager was working on a new tool to achieve this.

Systems and processes to safeguard people from the risk of abuse

● There was evidence accidents and incidents were recorded and usually reported as required to statutory bodies such as the CQC. There was no system in place to enable the manager to identify any emerging themes and trends in incident reports.

● Staff we spoke with could tell us how they would identify potential abuse, and understood the importance

of reporting this. Some staff said they would worry about making reports, particularly when this concerned other colleagues and their practice. We discussed this with the registered manager who told us about an isolated incident which may have caused this. They agreed there was work to do to restore staff confidence in these processes and said they would take action.

The evidence above, and that related to the dependency tool, contributed to a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● The provider followed safe recruitment practices by checking the work history of people applying to work at the home and ensuring that prospective staff were not barred from working with vulnerable people.

Preventing and controlling infection

● People's feedback about the cleanliness of the home and their rooms was almost all positive, and relatives told us they had never experienced closure of the home due to an infection outbreak.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

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

●The recording of people's capacity to make specific decisions, and the support given to them when they could not make these decisions, was weak. Care plans lacked documentation to show how and by whom capacity assessments had been carried out, for what decisions, and how consent had been obtained. Some care plans referred to best interests decisions, however there was no evidence to show how these decisions had been made, or who had been involved.
● Some people's DoLS had conditions attached to the authorisation which the provider was not meeting.

The above evidence shows the provider is in breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager's records relating to DoLS were not well organised and we found it hard to locate

information about people's current DoLS authorisations and any conditions that had been attached. Care plans contained a large amount of out of date paperwork relating to people's DoLS.

This evidence contributed to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Adapting service, design, decoration to meet people's needs

● Information about adaptation to fluids was not always robust. Some care plans stated the type and amounts of thickener to be used, whereas others lacked this information, and we saw a list on one unit which referred to a safe consistency for adapted fluids but not how to achieve these. Staff told us the prescribed thickener was not always used. One staff member said, "When we run out we just use someone else's." We were assured the correct thickener had been ordered before the end of our inspection.
● Records of people's food and drink intake on the upper floor were incomplete and did not show how people were being supported to lose, maintain or gain weight.
● Catering staff had not been made aware of people's current nutritional needs and preferences.
● On the first day of our inspection we saw people on the upstairs unit were spending all their time in the lounge and dining area in wheelchairs. There was only one lounge chair in the room and not enough dining chairs for the number of people. We raised this with the registered manager and they told us they would take action. On the second day we saw there were two lounge chairs and there were no more dining chairs. The unit accommodated 11 people.

This evidence contributed to a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

● Care plans for some people with a high level of support need to maintain nutritional health contained a good level of detail relating to how a person needed to be positioned and any adaptations they used to achieve this.

Staff support: induction, training, skills and experience
● All staff who were new to working in care studied for the Care Certificate on starting at the home. The Care Certificate is a recognised set of standards to equip people with skills for working in care. Staff received on-going training and had regular supervision meetings.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People we spoke with told us they were supported to see GPs and dentists when they needed to, and we saw evidence in people's records to confirm this.

Requires Improvement

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People being nursed in bed on the nursing floor lacked privacy as their room doors were kept open all the time. When we asked the registered manager about this on the first day of our inspection, they told us everyone had consented to this. However, care plans all contained the same information stating the person wished to have their door open, with no evidence their consent had been sought. We saw one person had covered their head, and when we asked staff why this was they told us it was because their door was open and they did not like this. Staff we spoke with said nurses wanted doors left open. We asked staff to check with the person, who did not wish to speak with us, and ask about their preferences. When we returned later in the day we saw their door was closed.
● We did not see people on the upper floor of the home supported to use the toilets if they needed to. One staff member told us this was because they used incontinence products.
● Staff did not always use respectful language. We observed one person exhibit behaviours which challenged them and other people. The staff reaction increased the person's frustration. A member of staff told us, "We take [name of person] to [their] room when [person] is being bad." In a care plan for another person who experienced challenging behaviours we saw instructions to call and inform a family member when the person was, 'Unpleasant.'
● On a number of occasions, we had to ask staff to be more discreet when discussing people and their care needs in communal areas. Phone calls to GPs to discuss people's health were made from the corridor, however people in the lounge were able to hear the conversations.
● Meals for people who required an adapted diet did not appear appetising, and staff were unable to tell us or the people eating them what the meals were. Some people who required assistance to eat did not receive this in a person-centred way.
● People gave some mixed feedback when asked if they felt they were respected. One person said, "Some staff will show respect, others don't." Other people were more positive, giving feedback including, "All the staff are very good, they have respect," "Staff treat me with dignity," and "Staff are very caring, they try their

best and listen to concerns."

The above evidence indicates a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

● Care plans included some information about protected characteristics such as a person's faith or cultural background. People who required diets appropriate to their beliefs of background told us they received these.

Requires Improvement

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns; End of life care and support

● People we spoke with said they knew how to raise complaints, and we saw there was a copy of the policy in people's rooms. Although there were some records of how complaints and concerns had been investigated, there was a lack of written feedback to people as promised in the provider's policy. This included a serious complaint relating to a lack of care provision for someone who had subsequently died.
● Although people had received a good level of end of life support, care plans lacked personalised information about people's wishes and preference for the care they wanted to receive at the end of their lives.

This evidence contributed to a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control;
● Some people were lacking control over their care planning and daily lives. On the upstairs unit we saw a 'daily routine' list which set times for various aspects of people's lives. Personal care was given from 5pm to 7.30, and after 7.30 the instruction to staff was to hoover the lounge, clear tables, complete all documentation and reset the room for the following morning.
● When asked, staff on the upstairs unit were often unable to tell us about people's health and support needs.
● Staff brought one person to the upstairs unit in an unkempt state. When asked, the staff said they had brought them upstairs because, "It is too big downstairs and (person) has really bad dementia." The person was very vocal and stated very clearly that they had not wanted to be brought upstairs.
● On the upstairs unit, care plans we looked at all contained a document which stated the person wished their door to be left open. We showed one person this document, and they became upset when they told us they were not aware of this and had not expressed such a wish. They told us they did not like people being able to see into their room.
● There was a lack of evidence in care plans to show how people had been involved in writing or agreeing to their care plans, and a varying amount of detail about important aspects of the person's life such as close

relationships or treasured memories the person may wish to be reminded of.

● We saw some planned activities taking part on the nursing unit during our inspection, however there was a lack of stimulus on the upstairs unit, where people spent their days sitting in chairs or wheelchairs. A relative told us, "Residents are very much left to their own devices." Feedback from people who used the service was mixed. Some people told us about activities they took part in, whereas others said they felt there was not enough for them to do.

Inadequate

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care;

- There were systems in place to check the quality of the service, however we found there was a lack of collation of findings and actions which the provider could use to drive improvement in the service. The audit regime at both management and provider level had failed to identify the issues we found at our inspection, which has led to breaches of regulations.
- There was a lack of evidence that care delivery and service culture were person-centred. Care was not always planned or delivered in ways which included people who used the service and their relatives. Some concerns with care delivery could have been identified and addressed by strong management presence and challenge in the home.

The above evidence shows the provider is in breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Minutes of meetings with people who used the service, their relatives and staff showed a range of issues were discussed, however they did not evidence how feedback from these groups was being used to drive changes or improvements in the service.
- A survey of people had been undertaken in May 2019, however the results of this had not yet been reviewed by the registered manager. We saw some negative feedback had been received and asked the registered manager to analyse the returns as a matter of priority.
- Staff and visiting health professionals also had opportunity to give feedback via a survey.

● People who told us they knew who managed the home gave broadly positive feedback about their relationship with the registered manager.
●The registered manager was aware of their responsibilities under the Equality Act 2010 and the Accessible Information standard. For example, the provider was preparing information in Braille to enable someone with a visual impairment to access their documentation independently.

Working in partnership with others
● The registered manger liaised with other bodies such as registered manager forums to share experience. Area managers shared relevant information with all the provider's services in the interests of developing a lessons learnt culture.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of evidence that people's capacity to make decisions was adequately assessed and managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff deployment was not well managed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity were not always respected.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Moving and handling practice was unsafe at times. Risk assessment and management were not always robust. Some gaps in recording of medicines were identified.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not adequately robust to ensure the service was consistently safe, effective, caring, responsive and well-led.

The enforcement action we took:
Warning notice