Care Quality Commission

Springfield Care Services Limited

Springfield

Inspection report

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13 January 2021
26 January 2021

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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 is a care home providing personal care for 69 older people.

People's experience of using the service
Risk assessments did not always contain the relevant information about people's known risks to mitigate or prevent incidents. Incidents and accidents were not always reported to CQC. Lessons learnt from incidents were not effective to prevent future occurrences. At times there were not always enough staff to meet people's needs. Recruitment processes were sufficient. We found medicines were not always managed safely. People told us they felt safe living at Springfield.

Quality assurance systems were not robust as the monitoring in place did not identify the concerns we found on inspection. Audits were carried out however, there was no overall action plan within the home. Meetings were held with people, their relatives and staff to ask for their views and their suggestions to improve the home.

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

Rating at last inspection
The last rating for this service was Good (published 19 June 2019).

Why we inspected
This was a planned inspection.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, 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? The service was not always safe. Details are in our safe 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**

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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
The inspection was carried out by two inspectors, a pharmacist and a specialist advisor for governance.

Service and service type
Springfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (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 announced on the morning of the inspection site visit. Inspection activity started on 13 January 2021 and ended on 26 January 2021. We visited the office location on 13 and 18 January 2021. We reviewed information sent to us by the provider and made telephone calls to people and their relatives on 19 and 25 January 2021.

What we did before the inspection
The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We reviewed information we had received about the service, such as details about incidents the provider must notify CQC about, for example incidents of abuse. We reviewed all other information sent to us from stakeholders such as the local authority and members of the public. We used all of this information to plan our inspection.

During the inspection
We spoke with five people to ask about their experience of the care provided and three relatives. We spoke with the nominated individual, registered manager and staff members. We looked at seven people's care records and seven medicine records. We looked at four staff files for recruitment. We also looked at quality monitoring records relating to the management of the service such as audits and quality assurance reports.

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 good. At this inspection this key question has now deteriorated 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Safeguarding allegations and incidents had not always been reported to CQC or the local safeguarding team. We found a number of incidents which had not been reported to CQC from April 2020 to December 2020.
• We spoke with one person who had alleged financial abuse. There was no evidence to suggest this had been investigated and appropriate actions taken to prevent this from re occurring. We discussed this with the registered manager who took actions to investigate the concerns.
• We were not always assured that lessons had been learnt from re occurring incidents. For example, one person had five unwitnessed falls in November 2020 and then a further eight unwitnessed falls in December 2020 which meant the risk had not been managed. Actions recorded to mitigate risks did not prevent re occurrence as these included checking sensor mats were working and checking for injuries after falls.
• Referrals made to health professionals for further advice on how to mitigate risks were not always followed up. For example, one person was referred to an occupational therapist in July 2020 due to deterioration in their mobility however, there was no evidence this had been followed up. The registered manager said they would follow this up immediately.
• People told us they felt safe however, not all relatives thought their relatives were safe living in the home. One relative told us they had raised safeguarding concerns about their relatives care due to deterioration in the management of pressure damage.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a safeguarding policy and staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them.

Assessing risk, safety monitoring and management
• People were at risk of avoidable harm because risk assessment documentation did not always contain the details staff needed to care for people safely. For example, we observed one person at high risk of falls being supported by two staff to stand however, the care plan recorded the person was independent with their mobility.
• Preventative actions had not always been taken when people were at risk. For example, we looked at one person's care records which stated they were to be observed every 30 minutes in communal areas and hourly when in their bedroom due to behaviours which challenged. These checks had not been carried out and staff we spoke with were unaware of the need to observe the individual to prevent possible risk.

• Risks were not always managed in the least restrictive way. For example, people's rooms on some units had been locked during the day following incidents of other people wandering into their bedrooms. There was no evidence of a best interest decision being made to determine whether other alternatives could have been considered rather than using restrictive practices.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Environmental health and safety checks were carried out and included gas, electric and fire assessments.

Using medicines safely
• Medicines were not always managed safely.
• Body maps were not always used by staff to record where a medicine patch had been applied previously. Using a different part of skin reduces the risk of skin irritation and side effects. We found three people had been treated by their doctor to treat the skin irritation from their patch.
• We found one body map which did not guide staff on where to apply a person's topical medicine. Medicines were not always available to give as they were out of stock.
• Some 'When required' care plans lacked the detail to guide staff on when they should be used so there was a risk that medicines would not be administered safely.
• We discussed these issues with the registered manager at the inspection and actions were taken to address the concerns.
This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• There were not always enough staff to meet people's needs. Whilst observing one unit we found the lounge area unsupervised for periods of time when staff attended to people's care in their bedrooms.
• There were several people requiring two to one support for their personal care needs with only two staff on each unit. The registered manager told us there was a floating senior available to support however, not all staff felt this was provided. For example, staff told us one person was at high risk of falls and had seven unwitnessed falls from October to January 2021. Staff were concerned that there was no person supervising people at high risk when supporting others in their bedrooms.
• The registered manager told us they used a dependency tool to identify how many staff were required for every shift however, we found this to be ineffective as it did not take into account those people that required 2:1 support for personal care. The Registered manager told us they were planning to review their dependency tool and staffing levels.
• The provider had robust recruitment checks in place to ensure staff were suitable to work in a care setting.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Infection and control audits were carried out to ensure the home was safe.
• The home was clean and tidy. We identified some chairs on one community which were worn and told these were due to be replaced.
• We observed staff members wearing protective equipment when carrying out personal care or when handling food to prevent cross infection.

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 good. At this inspection this key question has now deteriorated 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; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• We identified a number of incidents which had not been reported to CQC. For example, one person had fallen resulting in a head injury and required medical input. We have addressed these issues with the provider outside of the inspection.
• There was a lack of oversight and assessment of incidents and accidents. There was a clinical risk overview however, there was no clear analysis of trends over a period of time, to include details of when and where they happened and any injuries sustained, to subsequently reduce any apparent risks. We found incidents of unwitnessed falls had increased by 50 percent in November and December 2020.
• There was no overall action plan within the home to address ongoing concerns such as unwitnessed falls or improvements identified within audits. This was discussed with the register manager and the nominated individual who agreed to review the overall monitoring of the home.
• Records were not always completed or accurate. Risk assessments did not always contain the relevant information to mitigate against future risks. Observation charts had not always been completed and fluid charts did not contain information about fluid targets.
• People told us they felt able to raise concerns however, one person said they had not received any response about the actions taken.

This was a 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
• Staff said they were able to raise concerns with the management team however, did not always feel sufficient actions had been taken. For example, concerns raised about staffing levels.
• Surveys were carried out with staff however, surveys with people and their relatives had not been carried out. The nominated individual said these were being adapted and will be completed.
• Meetings were held with residents, relatives and staff to communicate any changes within the home and gather feedback from people.

Working in partnership with others

• The provider worked in partnership with health professionals when required.

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 The provider did not have systems in place to ensure the proper and safe management of medicines. The provider failed to ensure risk assessment's were robust and staff knew how to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure systems in place to assess, monitor and improve the quality of the service were being carried out to identify shortfalls and there was a lack of accurate and robust care records

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staffing levels within the home were sufficient.