

Antoni & Rienzie Limited

Springbank Rest Home

Inspection report

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Heywood
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13 February 2024

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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

Springbank Rest Home is a residential care home situated in Heywood, Greater Manchester. The service is registered to provide care for 20 people. At the time of our inspection there were 20 people living at the home.

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

The provider had not ensured risks to people had been thoroughly assessed and reviewed. Medicines were not always managed correctly.

Improvements were needed with the oversight of the service, as governance processes, such as audits were not being carried out. This meant the concerns we found during our inspection had not been identified. Some areas of the service environment need redecoration and improvement.

People and relatives were very happy with the care and support given at Springbank Rest Home. People told us they felt safe and well looked after. We saw many caring interactions between staff and people during our inspection and there was a relaxed, welcoming atmosphere at the service.

People were safeguarded from the risk of abuse and there was a stable staff team with enough staff on duty to support people well. Appropriate checks had been carried out when new staff were recruited. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection

The last rating for this service was good (published 25 April 2018).

Why we inspected

The inspection was prompted due to some concerns received about the governance of the service and the management of medicines. A decision was made for us to inspect. We undertook a focused inspection to review the key questions of safe and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

Please see the full report for further details. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Springbank Rest Home on our website at www.cqc.org.uk

Enforcement

We have identified breaches in relation to safe care and treatment and the provider's oversight and management of the service.

Follow up

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service was not always safe.</p> <p>Details are in our safe findings below.</p>	<p>Requires Improvement ●</p>
<p>Is the service well-led?</p> <p>The service was not always well-led.</p> <p>Details are in our well-led findings below.</p>	<p>Requires Improvement ●</p>

Springbank Rest 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 Health and Social Care Act 2008.

Inspection team

The inspection was carried out by an inspector, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced. Inspection activity started on 25 January 2024 and ended on 16 February 2024. We visited the service on 25 January and 13 February 2024.

What we did before the inspection

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

During the inspection

We looked around the service and checked the environment, equipment, and cleanliness to ensure the service was safe and fit for purpose. We observed the lunchtime meal and saw how staff interacted with people. We spoke with 13 people who used the service and 5 relatives about their experience of the care. We spoke with the registered manager and received 3 responses to the questionnaires we had emailed to staff for their comments about the service. We reviewed a range of records. This included 3 people's care records, medicine administration records and 2 staff recruitment files. A variety of other records relating to the management of the service were also considered as part of the inspection. These included training records, policies and equipment servicing records.



Is the service safe?

Our findings

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

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

Using medicines safely

- Medicines were not always managed safely.
- Prior to our inspection the local medicines' optimisation team had identified concerns regarding the safe management of medicines and had made some suggestions to improve the way medicines were managed. The registered manager had implemented improvements. During the inspection we found other concerns about the safe management of medicines which had not previously been identified.
- When people were newly admitted to the service there was no system for checking the medicines they brought into the service matched the medicines they were prescribed.
- Guidance was not always available to support staff to administer medicines, topical creams and fluid thickeners to people safely.
- Creams were not stored correctly in people's bedrooms.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence that people were harmed at the time of the inspection because the harm is not always immediate, however, people were placed at increased risk of harm by unsafe management of medicines. This demonstrated a breach of regulation 12 (g) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were stored at the correct temperature.
- Application of medicine patches was carried out correctly.

Assessing risk, safety monitoring and management

- The provider did not always assess risks to people's health and well-being.
- Some people did not have falls or choking risk assessments. Where people had risk assessments in place they had not been reviewed regularly. One person had fallen but their risk assessment had not been reviewed following this incident to see if any changes needed to be implemented to prevent a reoccurrence.
- People were not always protected from the risk of fire. A fire exit sign had fallen off the wall and not been replaced. There were some items on the ground outside a fire door preventing a clear exit. One person had a small, free-standing heater in their bedroom which was very hot. This had not been risk assessed to ensure it did not pose a fire risk. We have referred the service to the fire service to carry out their own inspection of the premises.
- Regular safety checks had not been completed on the window restrictors to ensure they remained fit for purpose.

The provider had failed to effectively assess the risks to the health and safety of people receiving care and failed to do all that was reasonably practicable to mitigate those risks. This was a breach of regulation 12 (a) (d) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Annual servicing of equipment was up to date.
- At our second visit to the service we found some improvements had been made to fire safety. However, the fire service had identified other concerns, which will be dealt with by their own enforcement process.

Preventing and controlling infection

- Improvements were needed to some parts of the service environment. There was an exposed porous surface, cracked tiles and rusty pipework in toilets/bathrooms. This made thorough cleaning difficult. Skirting boards and corridor walls were chipped and needed to be redecorated. Areas of the conservatory needed to be cleaned.
- There was an accumulation of broken equipment and litter in the garden. At our second visit this area had been tidied.
- Sufficient supplies of personal protective equipment (PPE) were available, and we saw staff using them correctly.

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

- Systems were in place to ensure people were safeguarded from the risk of abuse.
- People and their relatives were happy with the care and support provided by staff and felt safe at Springbank Rest Home. Comments included, "I feel very safe here. I have my buzzer if I need anything and somebody will come." A relative told us, "I have peace of mind knowing (relative) is safe at Springbank."
- There was a system in place to document and report safeguarding incidents, accidents and complaints.
- Staff had received training in safeguarding awareness and understood what actions they should take if they felt someone was being harmed.

Staffing and recruitment

- Staff were recruited safely. The required checks had been completed when new staff were recruited. These helped ensure they were suitable to work with vulnerable people.
- There was a stable staff team and there were enough staff on duty to respond to people's needs. People were supported by staff who knew them well. One relative told us, "The staff are consistent and know mum well. That makes a big difference."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS).

- The provider was working in line with the Mental Capacity Act.
- The registered manager submitted applications for DoLS to ensure people were not deprived of their liberty unlawfully.

Is the service well-led?

Our findings

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

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

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

- Improvements were needed with oversight of the service. Lack of quality assurance processes, such as audits and regular checks meant issues which we found during our inspection had not been identified by the registered manager or the provider.
- We found concerns with the environment, the management of risk, fire safety and medicines management (see the Safe section of this report).

Systems and processes had not been established to effectively assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection and feedback discussion the provider and the registered manager started to make some of the required improvements.

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

- The atmosphere in the service was relaxed and we observed kind and caring interactions between staff and people, which was indicative of a positive culture. People and relatives spoke positively about the staff and management team. One person told us, "The [registered] manager is brilliant, and the staff are very friendly."
- Staff told us the registered manager was approachable and supportive and Springbank Rest Home was a nice place to work in. A staff member told us, "I have worked at Springbank for 18 years and can't fault the care and the atmosphere of the job." Another staff member said, "The [registered] manager is very approachable and I feel I can approach her with anything if needed."
- The registered manager demonstrated an understanding of their responsibilities under duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The registered manager engaged well with people, their relatives and staff. Surveys had been sent to staff and people who used the service during 2023. We saw that responses were generally very positive.
- The service worked with local health and social care professionals to ensure people's health and

wellbeing were maintained.

- The service was working closely with the local authority to make improvements which had recently been identified through the local authority's own quality monitoring process.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to have safe and effective systems in place for the management of medicines.</p> <p>The provider had not ensured risk management strategies were in place to manage potential risks to people's safety.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance systems were not in place to monitor the quality of the service.</p>