North Yorkshire County Council

Springfield Garth

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Springfield garth is a care home providing personal care to up to 25 people. During the COVID-19 pandemic, the service has provided a safe environment for people who needed to leave hospital but still required care and isolation during their recuperation. At the time we visited nobody was using the service.

People's experience of using this service and what we found
People had experienced safe and person-centred care. They were supported by enough staff to meet their needs and staffs approach promoted their independence. Relatives told us their family members experience was dignified and of great value in supporting people to move from the care home back to their own home and independent living.

Since the last inspection the provider had reviewed their approach to quality assurance and governance. Unfortunately, the COVID-19 pandemic had stalled the implementation of any planned changes. We saw improvements had been made, however the old way of monitoring safety and compliance had been used and areas for improvement were not always identified. Following the inspection, the provider committed to implementing and embedding their new quality assurance approach.

The leadership of the staff team had been successful. The staff team had coped well changing the service to support people on discharge from hospital, including implementing good infection control measures. People and their relatives valued the service greatly.

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 requires improvement (published 03 May 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 21 March 2019. Breaches of legal requirements were found..

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we 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?

Good

The service was 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 Garth

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
Two inspectors carried out this inspection. One visited the service and the other made telephone calls to staff and relatives of people who had previpusly used the service.

Service and service type
Springfield Garth 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 gave the service 24 hours' notice of the inspection. This enabled us to understand the risks in relation to COVID-19 and ensure those risks were managed.

What we did before inspection
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 the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used this information to plan our inspection.

During the inspection
We spoke with three relatives of people who previously used the service about their experience of the care provided. We spoke with seven members of staff including the registered manager, service manager, deputy manager, care workers and the chef. We spoke with one professional.

We reviewed a range of records. This included three people's care records and multiple medication records of people who had previously used the service. We looked at one staff file in relation to recruitment. 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 looked at training data and quality assurance records.

Good

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 requires improvement. At this inspection this key question has improved to good. This meant people were safe and protected from avoidable harm.

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

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 been made at this inspection and the provider was no longer in breach of regulation 12.

- Care plans and risk assessments contained information to guide staff to keep people safe. On one occasion a person's needs in relation to diabetes were not clearly recorded. The provider agreed to ensure all health needs have a corresponding plan of care and risk assessment.
- The environment and equipment were managed safely.
- Medicines were managed safely. Plans were in place to ensure staff competency to administer medicines safely was checked.
- Action was taken when accidents or incidents happened. This action was not always recorded to evidence how the staff had minimised the risk of a reoccurrence.
- Please see the well-led section of this report to understand how these issues impact on the rating for this service.

Staffing and recruitment

- There was enough staff on duty to ensure people received responsive care and support. A relative told us, "Staff available knew my family member well, they took time to take them outside in the garden. This meant a lot to them."
- The provider operated a safe recruitment process.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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 was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse
● Staff understood how to protect people from abuse and how to recognise harm. They knew how to report concerns and were confident they would be appropriately dealt with by the registered manager.
● Staff took time to understand people's needs and support them to improve their health and wellbeing. A relative told us, "My family member didn't have a bad word to say. Staff were patient and understanding and took time to be there. My family member went from depressed and weak and was transformed both physically and mentally. I cannot speak highly enough of the level of care."

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 had not consistently embedded quality assurance systems to ensure quality and safety. Leaders and the culture they created did support the delivery of person-centred 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 effective systems were in place to monitor quality and safety. This was a breach of regulation 17 (Good Governance) 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 17.

● Quality and safety at the service had improved since the last inspection. The provider had reviewed their approach to quality assurance and governance following the last inspection. However, due to the COVID-19 pandemic this had not been implemented.
● The governance of the service did not always highlight where improvements were needed. For example; where a care plan did not contain details of how to manage diabetes care or where action taken following accidents was not recorded.
● An effective system to assess quality and safety was not embedded in practice. The provider committed to introducing the changes they had planned to strengthen their approach and to prevent safety and quality issues being missed.

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
● Staff were positive about the service they provided for people and there was a strong focus on supporting people to maintain or improve their independence. A relative told us, "My family member was well looked after and got their confidence back to go back to independent living." A member of staff told us the best thing about the service was, "The way we look after people, the encouragement, the support, the dignity, the compassion and the way we encourage people to be independent but we're there when they need us."
● The management supported staff and fostered an open culture. A member of staff told us, "We have a good management team, very supportive, open door, whenever you want to speak to them, they can address issues and we are not made to feel uncomfortable."

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

● Where things had gone wrong the provider had been open and honest with people who used the service and their relatives.

Working in partnership with others

● The registered manager and staff had worked successfully with a multi-agency team to provide safe care and support to people following discharge from hospital during the pandemic.