Horizon Care Springfield Limited

Springfield Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Springfield Grange is a residential care home providing personal and nursing care to 18 people at the time of inspection. The service can support up to 94 people. At the time of inspection two units in the home were open, the Rowan unit and the Willow unit. Three units were not in use.

People's experience of using this service and what we found
People were put at risk because the provider did not appropriately assess risk and did not take reasonably practicable steps to mitigate risk. Records showed people were displaying regular behaviours which challenge, staff were not sufficiently trained to manage and de-escalate such behaviours, and there was a lack of person-centred guidance around how to support people.

We found incidents were not routinely being referred to the local authority safeguarding team or reported to the CQC. People's medicines were not managed safely which put people at risk of not receiving their prescribed medicines. People did not receive appropriate dietary supplements when prescribed by a health care professional. Staff, people and relatives told us there were not enough staff to meet people's needs.

Staff did not receive appropriate support, training and supervision to enable them to carry out their duties. There were no effective systems in place to monitor and record people's food and fluid intake. Reasonable adjustments had not been made to enable people with a disability to enter the building. The home had not been adapted for people living with dementia. There was a lack of appropriate signage to help orientate people with a memory impairment.

We found references in people's care records which demonstrated they became distressed during care delivery. Best interest decisions were not appropriately documented. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff interactions with people were mixed. We observed on the first day of inspection that staff ignored some people and although saying they would come back to them, they did not. On the second day of inspection we saw some positive interactions between staff and people. Staff were kind and caring when interacting with people.

People did not receive person centred care. We found care and support records did not contain enough information to ascertain whether people's end of life wishes had been discussed with them. People and relatives told us they felt there were not enough activities to keep people occupied. We saw there was limited stimulation for service users and limited activities taking place. The provider did not demonstrate how they would meet people's communication needs of people with a disability, impairment or sensory loss.

People told us the service was not well led. The provider had not established and did not operate effective systems to ensure the service adhered to relevant legislation. For example, the provider had not registered Springfield Grange as a food premise. There were many instances of physical altercations between people who used the service and against staff. There was no evidence this had been identified and appropriately addressed by the provider. The provider was unable to locate paperwork when requested during both days of the inspection. There was little evidence of learning, reflective practice and service improvement. Data was not shared as required and there was little evidence of partnership working.

Everyone thought the staff were good and worked very hard. On the second day of inspection, staff told us things were starting to improve. In the reception area we saw the provider had started an employee special mention board. This was for other staff members, people, visitors and relatives to express their appreciation and recognise positive staff contributions. The home was kept clean. We saw complaints were investigated and responded to appropriately.

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

Rating at last inspection
This service was registered with us on 25 October 2018 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, moving and handling, lack of stimulation and people not receiving appropriate care and treatment. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

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

Following the first day of inspection the provider sent us information to explain how they will mitigate risk. They sent information regarding, fire safety and staff receiving supervision in relation to this, induction sheets for agency staff, a statement to say they will review the training matrix, rotas and staff skills mix, a commitment to review the use of dietary supplements, review pre-admission assessments, review pressure mattresses, allocate senior staff to oversee Springfield Grange and increase the number of visits by the nominated individual.

Enforcement
We have identified breaches in relation to the following, the provider failed to appropriately assess risks, such as managing behaviour which challenges; the provider was not taking reasonably practicable steps to mitigate such risk; medicines were not managed safely; there were insufficient numbers of competent staff; staff were not receiving appropriate support, supervision or training; people did not receive appropriate dietary supplements, when prescribed by a health care professional; care and treatment was not provided with the consent of the person or relevant person; care provided was not person centred; the premises were not suitable to meet people's needs; the provider did not have effective auditing processes to ensure the service provided safe and quality care; and, the provider did not assess, monitor and mitigate the risks relating to people's health, safety and welfare.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We identified a large number of instances where matters had not been notified to us as required by regulation. This is a breach of regulation 18 of the CQC (Registration) Regulations 2009.This will be dealt with outside this inspection process.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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.

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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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 first day of inspection was undertaken by two inspectors, a specialist advisor, whose area of expertise was in governance, 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. The second day of inspection was undertaken by two inspectors and a pharmacist specialist advisor.

Springfield Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. However, the registered manager no longer worked at the service but had not de-registered with the Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the service registered with the CQC. We sought feedback from the local authority and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with 13 members of staff including the nominated individual, regional manager, nurses, team leaders, care workers, the cook and domestic staff. 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 nine people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. 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 infection control audits, care plans, a list of staff supervision dates, staff meeting minutes, relative and resident meeting minutes, surveys, easy read complaints/compliments guide, an equality easy read document and daily notes recording information in connection with people moving units.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider failed to appropriately assess risks and was not taking reasonably practicable steps to mitigate such risk. For example, one person, who choose to eat whilst laid in bed did not have the risk of choking reflected in their risk assessment at the time of inspection. Following inspection, the provider sent the CQC information to demonstrate they had addressed this issue. One person's pressure relieving mattress was not set to the correct weight. This put them at risk of pressure sores. One person, who was at risk of developing pressure sores, was left sat in a wheelchair for over three and a half hours without being repositioned or asked if they wished to use the toilet.
- The provider did not appropriately manage risks in relation to behaviour which challenges. Three people had a significant number of instances regarding displaying behaviour which presented challenges to both other people and staff. Staff were not recording these instances consistently and they were recording incidents in different parts of people's care records. This made it difficult for the provider to have a clear overview. The regional manager told us they were aware of this and were to address this with staff at the next staff meeting.
- Records showed people were displaying regular behaviours that challenge, staff were not sufficiently trained to manage and deescalate such behaviours, and there was a lack of person-centred guidance around how to support people. Clear safeguards were not in place to manage behaviour which challenged to reduce the number of instances occurring.
- Following the first day of inspection, the nominated individual sent information to the CQC stating staff would receive supervision regarding managing challenging behaviour. On the second day of inspection we found not all staff had received this supervision.
- Fire management risk was not appropriately managed. On day one of inspection there were no records of fire alarm checks or fire drills and staff told us they had not received fire safety training. The nominated individual sent information to the CQC regarding fire safety on the evening of the first day of inspection.
- On day two of inspection, we saw evidence staff had received fire safety training and the staff spoken with were knowledgeable regarding fire evacuation. However, we found a fire escape on a first-floor unit was locked.

We found the provider failed to appropriately assess risk and take steps to mitigate such risk. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- We found incidents were not routinely being referred to the local authority safeguarding team or reported to the CQC. The regional manager told us they had put in place "a new checking system to stop this

happening again." This meant we were not assured people were being protected from avoidable harm.
● One person told us, "I feel safe, but it's scary listening to all the shouting which is all night and day." Another person told us, "Two who shout and bawl loudly all night. No one does anything about it."
● Not all staff had received safeguarding training. There was a risk staff would not identify and report abuse appropriately.

Using medicines safely
● The provider did not ensure the proper and safe management of medicines. People's emollient creams were stored in their rooms and did not contain the date they were opened. There were no risk assessments in place regarding creams being kept in people's rooms or a fire risk assessment in place where people had emollient creams. Medicines were not kept within the required temperature. For example, the temperature recorded on 1 July 2019 was 28 degrees and, on 2 July 2019, 26 degrees.
● There was unclear information regarding dietary supplements such as thickener. The information was not readily available to staff. There was no clear printed sheet to ensure everyone knew the correct amounts to be administered for each person. For example, we witnessed two staff members giving one person the incorrect dose and using the wrong thickener.
● PRN 'when required' medicines did not have clear protocols in place to ensure staff knew what medication was required, when it was required and what side effects to monitor for. For example, one person received paracetamol on a PRN basis. The protocol stated to monitor for signs of pain but there was no indication as to how the person would express their pain.
● The provider did not have a T28 exemption from the Environment Agency in order to denature Schedule 2,3,4 (part1) controlled drugs prior to disposal. A T28 exemption allows organisations to comply with the requirements of the Misuse of Drugs Regulations 2001 by making controlled drugs unsuitable for consumption.
● Medicine training records were inadequate and there was no clear overview of what training every member of staff had received.

We found medicines were not 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.

Learning lessons when things go wrong
● There were insufficient systems in place to ensure incidents were thoroughly investigated, reported, reviewed and monitored to prevent further occurrences. We found accidents and incidents had not always been reviewed and analysed to ensure appropriate and effective measures were in place to manage behaviour which challenges. This is addressed in the well-led section of the report.

Staffing and recruitment
● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff. People we spoke with told us the home did not have enough staff on duty. One person said, "They can chat to us, but not much because they're too busy, shorthanded." We observed there was a high number of new staff who were inexperienced and not equipped with the skills to meet people's needs. For example, one person, who was at risk of choking, was not sat upright in bed when food was being given. Staff were unable to supervise the person at all times due to insufficient staffing levels.
● One person's daily notes recorded, '[Person's name] was wet incontinent +++ washed & dried, dressed & currently in room, unable to fetch into lounge due to no staff available to watch [them].'
Staff told us there were insufficient staff on the Rowan unit in the morning, when service users wished to get up, and at night, when they wished to go to bed. One member of staff said, "Staffing levels are not meeting people's needs."

We found there were insufficient 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.

● Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny.

Preventing and controlling infection

● The provider completed infection control audits. However, these had not picked up on the issues we found such as; bins not having lids on, bins missing from the toilet and soap dispensers missing from people's en-suites.

● The home was clean and well presented. We observed housekeeping promptly attending to spills and cleaning up. Staff wore personal protective equipment, where appropriate.

Inadequate

Is the service effective?

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- People's needs were not appropriately assessed. One person had moved into Springfield Grange the day before the first inspection date. There were no care plans or risk assessments in place for this person. A staff member told us they found out this person was moving into Springfield Grange two hours prior to their arrival. The nominated individual provided a hospital discharge letter which showed the person had been admitted to hospital following a violent incident and had also been violent towards a staff member at the hospital.
- The care records contained limited information regarding people's needs and choices. For example, one person's care record stated they could present with anxiousness due to communication and sensory barriers. However, there was no information to explain what this meant in relation to the person or how staff should support the person to ensure their needs were met.

Staff support: induction, training, skills and experience

- Staff did not receive appropriate support, training and supervision to enable them to carry out their duties. For example, there was no evidence to demonstrate two staff members had received induction training despite starting employment in October 2018 and April 2019.
- There was no evidence to demonstrate staff received regular supervision and completed mandatory training. Where staff had completed training but scored less than 60% this had not been addressed by the provider to ensure the training had been effective.
- There was no evidence to demonstrate all staff had received supervision regarding managing behaviour/de-escalation. The nominated individual said they could not find the supervision regarding the challenging behaviours and they believed all the supervision records were waiting to be filed but could not locate them. It was evident from people's records that staff did not have the skills or expertise to appropriately manage behaviour which challenges. For example, one member of staff noticed a person had the laptop and asked for it back. This distressed the person, as the laptop was important to them at that moment in time. The person shouted and hit the staff member. Another person saw this and punched the person with the laptop in the face. The member of staff displayed no awareness of how to work with the person to prevent behaviours which challenge. The situation escalated resulting in the assault of two people.
- On day one of the inspection, despite requests, the inspection team were not provided with a training matrix or supervision matrix. There was no evidence to show the provider had an overview of people's training and support needs. On day two of inspection, the inspector asked to see a supervision matrix, this was not available at inspection. A list of dates staff had received supervision was emailed to the CQC following the second day of inspection. We were provided with a copy of the staff training matrix on the

second day of inspection, but the nominated individual stated this was not fully up to date.

Staff did not receive appropriate support, training or supervision to enable them to carry out their role. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● There were no effective systems in place to monitor and record people's food and fluid intake. For example, we observed a staff member filling in food and fluid charts for everyone at approximately 11am. We asked how they knew what everyone had consumed. The staff member tapped their head and said, "It is all up there" and they could remember.
● People were not provided with suitable and nutritious food and hydration which was adequate to sustain life and good health. For example, one person had lost 14kgs between 21 February 2019 and 6 June 2019. The GP had prescribed supplement drinks. The person's nutrition care plan recorded the person as having a 'normal diet and fluids, on food & fluid chart'. We found no evidence to show the person had received fortified meals or given regular snacks. This put them at further risk of losing weight.
● People did not receive appropriate dietary supplements when prescribed by a health care professional. For example, we saw staff giving one person the incorrect dose and using the wrong thickener.
● We saw advice from other healthcare professionals was not followed. For example, the speech and language team (SALT) advice for one person, dated 29 May 2019, stated they were to use a teaspoon to eat. We saw on both days of inspection this person ate with a tablespoon instead of a teaspoon.

The provider did not ensure people received suitable and nutritious food and hydration or dietary supplements as prescribed. This was a breach of regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider used a specialist company who provided pre-prepared frozen meals which included catering for people with a specialist diet. This helped to make sure people had a balanced diet. People had a choice of food and drinks available throughout the day.

Adapting service, design, decoration to meet people's needs
● Grab rails were not available in all en-suite rooms, the provider told us an individual assessment for these would be done when required. Soap and paper towel dispensers were not always installed. The bedrooms, which were unoccupied at the time of inspection, on the lower ground floor had glass doors but no openable windows to vent the rooms. The bedrooms in the top of the building had sloping ceilings and had Velux windows which did not enable as clearer view as a standard window.
● One person was taken into the garden area to have a cigarette. When they had finished, they were unable to re-enter the premises and were left outside. Reasonable adjustments had not been made to enable the person to re-enter the building.
● The premises had not been adapted for the people who lived there. The walls on the Rowan unit were beige and there was nothing tactile for people living with dementia to focus and occupy them. There was a lack of appropriate signage to help orientate people with a memory impairment.
● Staff struggled to work in hot conditions in the laundry room in the basement of the building with no window, and little ventilation other than open doors. There was an air-conditioning unit, but this offered little relief unless stood directly in front of it.
● In the kitchen, there was no window or obvious signs of ventilation, other than the door remaining open onto the corridor which led to an open outside door. The nominated individual stated there was inbuilt ventilation system. However, due to hot temperature, the inspection team found this was not effective. A fan

had been provided to staff, but this just circulated hot air and did not help. A book recorded the temperatures within the kitchen, these reached 34 degrees.
● There was limited cold food storage which made it difficult to keep sandwiches cool for the 17 people who lived at Springfield Grange. The kitchen premises were not suitable to store cold food for 94 service users, the maximum number the home was registered to accommodate.

Premises and equipment were not suitable to meet people's needs. This was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● We saw evidence other healthcare professionals were involved in people's care. For example, GPs, SALT and the mental health team. However, we saw advice was not always followed.
One person told us, "They'd get a doctor if I wanted one." Another person told us they were not able to access the dentist despite requesting this.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Best interest decisions were not appropriately documented. For example, when key decisions about care were made around people moving to a new unit, brief consultation notes with family members were recorded in people's daily notes. There was no record of an assessment of capacity, no detailed consultation notes and no record of the best interest decision. One person had a bed and mat sensor in place. The CQC were sent information in relation to a best interest decision for a crash mat but, there was no documentation regarding the best interest decision in relation to a bed and mat sensor.

Care and treatment was not provided with the consent of the person or relevant person. This is a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found references in people's care records which demonstrated they became distressed during care delivery. We found references in one person's care record that personal care was carried out where they had made it clear they did not want to receive personal care. It was evident from the records that staff did not recognise this. There had been no attempt to try different approaches to gain the person's consent. We found there was a lack of guidance within the person's care plan to show staff in how to best provide care and support.

● Care and treatment were not provided in a way that protected service users from abuse and improper treatment. One staff member told us, "Personal care-assist on the toilet with force, up here on a regular basis... Assist on the shower with a bit of force, when shower on will calm down, with [name of person] resist every time, has a wash every day."
● We saw evidence in one person's care records to demonstrate staff did not recognise people could choose whether to receive personal care and that there had been no attempt to find a least restrictive option to provide necessary care and treatment. For example, one person's daily notes recorded '[three staff] assisted [name of person]] into shower, [person] wasn't happy, but we managed to do it, we washed [their] hair…'

People were not safeguarded from abuse and improper treatment. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLs applications were made where appropriate and a record kept detailing when they were due to be reviewed. One person told us, "I can go to bed and get up when I want." Another person said, "I can shower when I want, but I must have a carer."

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- One person told us people shouted out all night. They said it was constant and they had lost so much sleep. They said they had reported it to staff but nothing had been done. We observed wheelchairs were not being used by the people they were intended for but were interchanged and used by different people.
- We observed on the first day of inspection that staff ignored one person and although staff said they would come back to them, they did not. A visitor told us they had to leave the home early because someone had been calling all the time for a cup of tea and the staff told them they were too busy. One person commented, "Summer is passing me by. Just like winter did."
- On the second day of inspection we saw some positive interactions between staff and people. Staff were kind and caring when interacting with people. One member of staff picked up one person's cue they were warm and asked them if they would like to take their hoodie off. They assisted the person to do this. Another member of staff noted one person was using their clothing to wipe their nose, so they brought them a tissue.

- Everyone thought the staff were good and worked very hard. One relative said, "The staff work very hard. They're nice staff."

Supporting people to express their views and be involved in making decisions about their care

- We saw examples of people being supported to make decisions. For example, people were offered a choice of drinks and food. We saw one staff member physically show people choices to help them make a decision.

Respecting and promoting people's privacy, dignity and independence

- One person told us, "The staff are kind and caring." Staff told us how they promoted people's privacy and dignity. One staff member said, "Making sure people are comfortable and equipment and towels are ready."
- Staff explained how they promoted people's independence. For example, one staff member told us, "I talk people through things and encourage them to wash. Describing the items." Another member of staff said, "[I encourage them to] wash parts they can. Handing them the soap." One person wanted to sit down, and a staff member assisted the person to do this in a kind and encouraging way. They clearly explained what was happening and explained to the person where the chair was.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's life histories were extremely limited, so it was difficult to understand their background, relationships which were important to them, details of hobbies and past occupations.
- Information in people's care plans did not give sufficient guidance for staff to provide person centred care. For example, some people remained in bed and it was not always evident from care records this was their genuine choice and how many times they had been asked if they wished to remain in bed.
- Where care plans did contain personalised information, staff were not always aware of this. For example, one person's care record stated they were registered blind in their right eye and that staff should approach them on the left. We observed staff approach was variable. One member of staff sat on the person's right side and the person shouting for the nurse as they were unable to see the staff member. Another staff member sat on the person's left side whilst playing dominoes.

The provider was not ensuring people received person centred care and treatment which met their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- We found care and support records did not contain enough information to ascertain whether people's end of life wishes had been discussed with them. For example, one person had a Do Not Attempt Resuscitation form(DNACPR) in place, but there were no details about their end of life wishes. This meant the views and wishes of people had not been considered.
- There was no evidence to demonstrate the provider consistently engaged people in planning their end of life care, or recorded and acted on individual wishes. Staff were unsure who was receiving end of life care

The provider was not ensuring people received person centred care and treatment which met their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care was not person centred; there was limited stimulation for service users and limited activities taking place. People sat or walked around passively, not engaged with meaningful activity. There was limited interaction between people and staff.
- The timetable of activities was not person centred and did not reflect people's choices. The activity

coordinator told us they had begun to get to know people and had planned to create sensory boxes, arrange outdoor activities and look at evening activities. The activity coordinator worked 8am until 4pm Monday to Friday. There were no activities outside these hours. One person told us, "There is very little going on." People and relatives told us they felt there were not enough activities to keep people occupied. One relative said, "There's nothing for them to do. No activities. I know [my relative has] got dementia, but there should be something to occupy the residents." Another relative said, "When they go in the gardens' there's nothing for them to do. They just sit there. Look out the window, there's nothing for them. They just sit at the tables there."

● There was no evidence to demonstrate people had been considered or consulted when looking at activity planning. This meant the provider did not make every effort to ensure service users were involved in making decisions about their care and support.

The provider was not ensuring people received person centred care and treatment which met their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● We saw complaints were investigated and responded to appropriately.

● The regional manager showed us how complaints were logged and that they were able to oversee these, along with the human resource department. There were electronic reminders to help make sure complaints were responded to in a timely manner.

● The regional manager also recorded informal low-level complaints. They told us they looked for patterns and trends.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Following inspection, the provider sent information regarding AIS. They sent us an easy read complaints/compliments policy and an equality easy read document dated April 2013, which referred to Sheffield City Council. This policy was not relevant to Springfield Grange. The provider did not demonstrate how they would meet people's communication needs of people with a disability, impairment or sensory loss.

● People had communication care plans in place which detailed information regarding any impairment they had and what aids they used. However, staff were not following the care plan or were unaware of the content. One person's care plan stated the person's 'vision appears good' but there was no confirmation they had seen an optician for a professional opinion. The communication care plans we requested on the second day of inspection recorded these care plans were 'last updated: 03/07/2019', following them being requested at inspection.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. 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.

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

- The provider had not established and did not operate effective systems to ensure the service adhered to relevant legislation. For example, at the time of inspection the provider had not completed their registration of Springfield Grange as a food premise, they did not have a T28 exemption from the Environment Agency in order to denature Schedule 2,3,4 (part1) controlled drugs prior to disposal and had failed to report relevant matters to the local safeguarding authority and the CQC.
- The provider did not appropriately assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. There was a lack of review of accident and incidents. There were many instances of physical altercations between people who used the service and against staff. There was no evidence this had been identified and appropriately addressed by the provider.
- Staff were unsure where to record incidents on the electronic care recording system. Staff were using different sections within people's records. The regional manager recognised this and planned to provide guidance to staff on what to class as an accident/incident. They stated this would be discussed at the next staff meeting.
- There were inadequate governance systems in place. The provider did not appropriately assess, monitor and improve the quality of the service. Quality audits did not adequately identify areas in need of improvement. The issues identified on both days of the inspection had not been picked up through the provider's systems and processes. For example, the medication audits had not identified there were no risk assessments in place regarding storing creams in people's rooms or for fire risks around emollient creams.
- The regional manager told us accidents and incidents were looked at through the manager's daily report. As there was no manager in place at the home, the regional manager was currently doing this, and checking incidents had been appropriately notified. There was an accident and incident analysis tracker in place, but it did not record people's names and therefore further investigation would be needed to flag up if the same service user or staff member were involved. This system did not work, as the provider had failed to notify a number of incidents to the CQC and had not appropriately assessed and mitigated people's risks in relation to behaviour which challenges.
- Shift handovers were recorded separately within people's daily notes. There was no overview of every person's handover available to staff. Staff would have to go into everyone's daily notes, which could make it difficult for staff to be aware of any issues for each person.
- The provider was unable to locate paperwork when requested during both days of the inspection. For example, fire records, supervision records and paperwork to support a review of people's behaviour which

challenges, was reported as being left at the previous registered manager's home.
● One member of staff told us policies and procedures were kept in the management office, but they were unable to access out of hours (after 4pm). We saw a notice in the staff room which stated, 'policies and procedures for safeguarding and WB [whistleblowing] available in registered managers office.'

Systems and processes were not established and operated effectively. The provider did not assess, monitor and improve the quality and safety of the service provided. The provider did not assess, monitor and mitigate the risks relating to people's health, safety and welfare. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified a large number of instances where matters had not been notified to us as required by regulation. This is a breach of regulation 18 of the CQC (Registration) Regulations 2009.This will be dealt with outside this inspection process.

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
● People told us the service was not well led. One person said, "No, there's no meetings." Another person said, "I wouldn't recommend it here. They're short staffed. You can't do this, and you can't do that."
● Staff were not adequately supervised and were not routinely listened to. Staff had raised concerns about how hot their working environment was, but this concern had not been acted on. When we raised this with a director of the company at inspection, they denied the building was too hot.
● People who used the service were not adequately consulted or listened to. For example, there was limited information regarding their personal history, and activities were not planned to meet people's needs.
● The provider completed a staff survey in May 2019 which had three responses. A visitor's survey was completed in June 2019 and had two responses. The home had a 'you said, we did' board to document where they had involved and engaged people, the public and staff.
● In the reception area we saw the provider had started an employee special mention board. This was for other staff members, people, visitors and relatives to express their appreciation and recognise positive staff contributions. On the second day of inspection, staff told us things were starting to improve.

Continuous learning and improving care; Working in partnership with others
● The provided had begun to build up links with the local community. For example, in December 2019 the home held a 'tea and cake' open day. The activity coordinator acknowledged they were looking to build strong links with the community.
● There was little evidence of learning, reflective practice and service improvement. Data was not shared as required and there was little evidence of partnership working.