Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Southfield Care Home is a residential care home providing personal care to up to 54 people. people. At the time of our inspection there were 24 people living at the home. Southfield Care Home accommodates people in one adapted building over two floors.

People's experience of using this service and what we found
The provider had not demonstrated continuous improvement and had failed to ensure safe and effective governance of the service. Medicines were not always managed safely which meant people were at risk of harm. The specific issues we had raised with the provider at the last two inspections had not been fully addressed.

The provider had updated the format of some care plans and risk assessments. However, we continued to find examples where information was contradictory, and records had not been reviewed to reflect changes in people's health and social care needs.

Recruitment was managed safely. Systems were in place to safeguard people from abuse and neglect.

Over the course of the inspection we observed the atmosphere was calm and relaxed in the home. People appeared to be well cared for and we observed warm and friendly interactions between staff and people.

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 inadequate (published 21 April 2022) and there were breaches of regulation.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 10 and 17 March 2022. Breaches of legal requirements were found. We undertook this targeted inspection to check the provider now met legal requirements. We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement and Recommendations
We have identified continuing breaches in relation to the safe management of medicines and good governance.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

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.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Southfield Care 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.

This was a targeted inspection to check whether the provider had made improvements since our last inspection.

Inspection team
The inspection was carried out by two inspectors and a pharmacy specialist.

Service and service type
Southfield Care 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. Southfield Care 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post. However, the manager completed their registration with CQC on 17 June 2022.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service since the last inspection. 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 (PIR) prior to the inspection. This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We looked around the building and observed people being offered care and support in communal areas. We spoke with six members of staff including the nominated individual, manager, team leaders, care staff and the cook. The nominated individual is responsible for supervising the management of the service. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including audits and policies.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had made improvements where we had identified breaches in regulation. We will assess the whole key question at the next inspection of the service.

Using medicines safely

At our last inspection systems were not robust enough to demonstrate medicines were managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicines were not always managed safely. Specific issues we raised at the last two inspections had not been fully addressed.
- People's medicines were not always available to them. The manager told us they had changed their pharmacy to support improvements. However, we found two people had run out of the same medicines on two occasions. This meant people were placed at risk of harm and we were not assured the provider was identifying and resolving issues promptly.
- Protocols were not in always in place for all medicines prescribed to be taken 'as required'. Those that were in place did not always provide consistent and person centred information.
- Systems to manage and record the administration of topical medicines had improved. Creams were stored safely. However, we continued to find discrepancies and a lack of guidance for staff about how and where creams should be applied.

Systems had not been established to ensure people were administered their medicines safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They sent us updated copies of 'as required' medicines protocols and we reviewed these as part of the inspection.

Assessing risk, safety monitoring and management; 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(1) 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.

● Risks to people's health and safety were not always managed properly.
● A range of risk assessments were in place including information about bed rails, falls, eating and drinking and pressure care. However, we found some risk assessments were not detailed and had not been updated when changes occurred.
● Where risks had been identified there was not always a care plan in place. For example, one person had experienced an increase in falls. There had been no changes made to their mobility and moving and handling risk assessments. However, the provider had referred this to the district nurse team and had taken appropriate action to mitigate the risk, including ordering a sensor mat for the person.
● Where people were losing weight risk assessments were not always detailed. However, we found where concerns were identified close monitoring was in place and advice sought from appropriate health professionals.
● Some people's care records had been fully reviewed and new systems were in place to monitor changes. For example, there was a new format in place for staff to record their daily observations.
● Environmental risks were not always managed. This is reported on under the well-led section of this report.
● Accidents and incidents were recorded. The provider had improved how this information was reviewed or used to reduce the risk of similar incidents occurring but further improvements were needed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to demonstrate that people were safeguarded from abuse and neglect. This was a breach of regulation 13 (1) 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 13.

● Systems were in place to protect people from abuse or neglect.
● Where there were allegations of abuse referrals had been made to the local safeguarding authority and actions taken to mitigate future risks. There was evidence the manager worked closely with the local authority.
● Staff had received up to date safeguarding training.

Recruitment

At our last inspection the provider had failed to ensure systems were in place to recruit staff safely. This was a breach of regulation 19 (1) 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 19.

● Recruitment was managed safely. The required checks had been made to ensure staff were suitable to work in a care setting.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had made improvements where we had identified breaches in regulation. We will assess the whole key question at the next inspection of the service.

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

At our last inspection the provider had failed to robustly establish systems to assess, monitor and improve the quality of the service provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The provider had not demonstrated continuous improvement and had failed to ensure safe and effective governance of the service. Although we found some improvements had been made in some aspects of the running of the home, we found continued non-compliance with regulations.
● Quality assurance systems were not effective in identifying and addressing issues and risks we found at this inspection. Audits had not identified shortfalls in record keeping or safe medicines management.
● There was no robust system for assessing and managing risks to people's health and safety. This meant people were at a heightened risk of injury and their health and well-being deteriorating. Some care records continued to be inaccurate and lacked person centred information. The manager told us there had been no audits of care records in April or May 2022 because they had been concentrating on writing new care plans.
● We were not assured checks to the building were always robust. We identified several hand wash basins accessible to vulnerable people living at the home where the hot water temperature was at least fifty degrees C. This exposed people to a significant risk of scalding. This had not been picked up by daily checks. We reviewed the water checks completed on 6 June 2022 and found no concerns had been highlighted. However, the temperatures for the baths and showers in the home were recorded as low. We discussed this with manager, and they told us they would review this. The provider took immediate action where the temperatures were over 50 degrees C, and this was resolved on the day of the inspection.
● Cover arrangements in the absence of the manager had not been robust. Whilst the manager was absent there had been a referral made to safeguarding by an external professional. The service was notified of this but had not notified the Commission. Registered providers are legally obliged to inform the Care Quality

Commission (CQC) of certain incidents which have occurred. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. The manager was open and honest about the failing and they told us they would ensure there would be improved systems to prevent a re-occurrence.

Systems had not been established to assess, monitor and improve the service provided. Quality checks had not identified shortfalls. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found the provider had made some improvements. There was a clear and accessible policy file available to staff and detailed environmental risk assessments had been updated.
- The manager was open and honest throughout the inspection and expressed their commitment to improving the quality of the service.
- Over the course of the inspection we observed staff working well as a team and saw warm and caring interactions between staff and people. The atmosphere was calm and welcoming throughout the inspection.