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Southlands Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection to Southlands Rest Home on 21 November 2017. This inspection was carried out to follow up on some concerns we had received regarding the level of care and the quality of the service people received at the home.

Southlands Rest Home 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. Southlands Rest Home is a home that provides accommodation and personal care for up to 19 people. The majority of people at the home were living with dementia or other mental health conditions. At the time of our inspection there were 16 people living at the home.

The home is owned by Mr and Mrs Sohun. Mrs Sohun is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspection in July 2016, breaches of legal requirements were found and we took enforcement action against the provider. We issued warning notices in relation to safe care and treatment, staffing and good governance. As a result of our concerns Southlands Rest Home was placed into special measures. The provider wrote to us to say what they would do to meet legal requirements. We undertook a further inspection in March 2017 to check the provider had taken action to meet the regulations. We found the provider had made improvements in the quality of care people received and the service was removed from special measures. At this inspection we found these improvements had not been sustained and identified concerns regarding the way in which the home was managed.

There was a lack of managerial oversight within the service. The provider who was also the registered manager had not identified shortfalls with the care people received or poor practices in staff performance. Safeguarding incidents had not been identified and reported to the local authority safeguarding team or to the CQC. There was a lack of understanding with regard to the responsibilities as registered persons to report significant events to the CQC.

Systems implemented to monitor the quality of the care provided had not been sustained and were therefore not effective in ensuring people received the care they required. The provider and registered manager had not ensured that people were at the centre of the service. The culture and values of the home described by staff and the registered manager were not embedded in to practice which meant people's choices were not always respected. Although people were asked to give feedback on the home, action was not always taken as a result of their comments.

Risks to people's safety and well-being were not always identified and acted upon. Accident and incident forms were not completed in detail and were not reviewed to minimise the risk of events happening again. Risk management plans were not always followed by staff and did not always fully address the risks identified. There was a smoking room on the ground floor which did not meet with current legislation regarding smoking in care homes. The smell of smoke permeated throughout the ground floor and no risk assessment was in place regarding this. Medicines were not always managed safely. The key to the medicines cabinet was left unattended and we found gaps in the recording of people's medicines. People and staff told us they felt there were sufficient staff deployed to meet their needs. However, we identified times when people were left without staff support in communal areas which left them at risk.

Safe infection control practices were not followed and areas of the home were dirty with strong malodours. Not all bathrooms and communal toilets had hot water, soap or paper towels. There was no cleaning schedule in place to guide staff. A number of areas in the home required refurbishment although no plans were in place to address this. The provider had not developed a contingency plan to ensure that people would continue to receive safe care in the event of an emergency. Although individual personal emergency evacuation plans were in place the overall fire risk assessment for the premises was out of date. However, fire equipment was regularly serviced.

Staff did not receive comprehensive training or supervision to support them in their roles. Whilst staff were able to describe the training they had received they did not always demonstrate these skills in practice. People did not always receive support from staff who had been recruited safely. We found two staff members did not have any references to guide the provider on their suitability for their role. Staff told us they felt supported by the registered manager.

People's legal rights were not protected as the principles of the Mental Capacity Act 2005 were not followed. Capacity assessments were not decision specific and best interest decisions were not recorded. Not all restrictions to people's liberties had been identified when completing DoLS applications.

People were not routinely provided with choices regarding drinks or food. We observed everyone was provided with the same drink and no choices were offered. People's comments regarding food had not been taken into account and no menu was available. Meal times were task focussed and staff did not take the time to ensure people were comfortable and had the support they required. We received mixed reviews from people regarding the quality of the food provided. People's dignity was not always protected. People did not always receive personal care in line with their needs and many people looked unkempt. Staff did not always knock on people's doors before entering.

People did not always have access to activities in line with their needs and preferences. Although some activities were organised there were significant amounts of time when there was no stimulation apart from the television. People had access to health care professionals although this was not always provided in a timely manner. Staff were not aware of people's past lives and were unable to fully describe people's care needs and personalities. Care plans did not give up to date guidance to staff regarding the support people required and people's end of life care wishes were not recorded. Although some people were supported to maintain their independence, others were not provided with the equipment they required in order for them to eat independently.

On the whole staff interacted with people in a kind manner. People's religious needs were respected as people had access to local church services. Relatives told us they felt welcome when visiting the home and no restrictions were in place on visiting hours. The provider had developed a complaints process which was shared with people and relatives.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During our inspection we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not fully understand their responsibilities in safeguarding people and safeguarding concerns had not been shared with the local authority.

Accidents and incidents were not comprehensively recorded and action was not always taken to minimise risks. Risks to people's safety were not always identified and addressed.

People received the medicines they required but there was a lack of good medicines management processes in place.

People were not always cared for by a sufficient number of staff and at times people at risk were left without staff support. Safe recruitment processes were not always followed.

Safe infection practices were not followed and areas of the home were unclean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's legal rights were not always protected because staff did not always work in accordance with the Mental Capacity Act (2005).

Staff did not receive effective training and supervision for their roles.

People gave mixed reviews on the food and drinks provided and choice was not always available.

People had access to healthcare services although referrals were not always made in a timely manner.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated in a respectful way by staff. People's personal care needs were not fully met and their independence was not always encouraged.

Staff did not always knock on people's doors before entering to ensure their privacy.

People's cultural and religious needs were met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have access to activities to help ensure they were not isolated.

People did not always receive responsive care as staff did not know people's needs well and care plans lacked detail.

People had access to a complaints policy.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of management oversight within the home as the registered manager told us they were not aware of some of the concerns we identified.

Quality assurance processes were not effective in identifying shortfalls in the care people received.

The culture and values of the home were not followed or embedded into practice.

The provider had failed to notify the Care Quality Commission of significant events in line with statutory requirements.

Southlands Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered manager is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by concerns raised regarding the care people were receiving at Southlands. During the inspection we identified that safeguarding concerns were not being reported to the local authority safeguarding team and that accidents and incidents were not routinely recorded and actioned. Following the inspection we alerted the local authority to our concerns and shared information regarding the specific incidents we had identified. The local authority safeguarding team are currently working with the service in order to minimise the risks to people's safety and care.

This inspection took place on 21 November 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we gathered information about the service. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were following up on concerns we had received.

As part of our inspection we spoke with five people, three relatives, the registered manager, deputy manager and four staff. We observed interactions between people and staff. We reviewed the care plans for six people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at three staff recruitment files and records of staff training and supervision. We saw records of

quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff, people and relatives.

Inadequate

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. One person told us, "There is always someone around. We are never left totally on our own." Another person said, "If I press my buzzer they usually come pretty quickly." One relative said, "I don't worry about him." Another relative told us, "I don't worry that she is unsafe when I leave."

Despite these comments we found that people were not always cared for safely.

Accidents and incidents were not comprehensively completed and not analysed to ensure appropriate action had been taken to keep people safe. The accident and incident file did not contain details of the safeguarding incidents described above. In addition, one incident form described someone had fallen and been taken to hospital although there was no record of the outcome of this. We spoke to the registered manager who told us the person had sustained a serious injury as a result of the fall. There was no evidence to show that accidents and incidents were reviewed or that trends were monitored in order to help ensure this did not happen again.

Risks to people's safety were not always identified and managed. The registered manager had not considered the risk to people's safety and health in relation to the smoking room at the home. When we arrived there was a strong smell of smoke permeating throughout the ground floor. We found the smoking room was contained within the home, directly opposite the kitchen and a short distance from the main lounge. The door to the smoking room was open and one person was smoking. There were three full ashtrays, the windows were closed and the door open. There were no safety notices or fire equipment contained within the room. Legislation states that smoking in care homes is prohibited unless in designated areas which are clearly signed and meet with regulations. Although individuals who smoked had risk assessments in place there was no overall risk assessment regarding the smoking room. This meant that the safety of others living in the home had not been considered. We discussed the impact the current smoking room may have to the health of others with the registered manager as no consideration had been given to the fire risks or to the fact that people were being exposed to passive smoking. They told us that the room was normally signed but had been removed as the door had been painted. The smell was so strong that whilst sitting in the lounge with people we observed on person shout at another person, "Stop smoking." We explained to the person that no one was smoking in the lounge.

One person had recently experienced a fall and had sustained extensive facial bruising. The person's room was on the top floor of the home. A sensor mat was in place to alert staff when the person got out of bed but the person had been able to bypass this. Although furniture had been moved in an attempt to prevent this, no other action had been taken in relation to their safety. The positioning of the person's room put them at risk of falling down the stairs should they come out of their room without staff support as there was no barrier such as a gate or an alarm in place. Risk assessments in place did not address this concern and had not been updated following the person's fall. Following the inspection we alerted the local authority who took action to ensure the person's safety. Another person's care records highlighted they had a history of falls if they walked too fast. Their care plan stated, 'staff to provide a risk assessment for me'. However there

was no risk assessment in place. Where risk assessments were in place guidance was not always followed. One person had a history of touching female residents inappropriately. Their risk assessment stated they should not be seated next to female residents. We observed this guidance was not followed by staff and the person sat next to a female resident for part of the day. We spoke to the registered manager regarding these concerns. They told us that there had been no incidents for several months but they would ensure that staff were reminded.

Monitoring of people who may be at risk of malnutrition was not always followed up by staff. We noted from the records that at least three people appeared to have lost five kilogrammes within a three-month period. However there was no record to show what action had been taken. There was no evidence that GP's had been contacted to ensure the people were not suffering from any underlying health concerns. Staff had not been informed of the need to monitor people's weight more closely and no referrals had been made to dieticians. The registered manager assured us that action would be taken to contact the relevant healthcare professionals.

Safe medicines practices were not always followed. Each person had a Medicines Administration Record (MAR). This had a photograph of the person for identification purposes and also included information on any allergies a person was subject to and any other relevant information in relation to their medicines. Although we found evidence that people had received their correct medicines, we noted some gaps in records and a lack of protocols for people who required 'as needed' (PRN) medicines. Seven people did not have PRN protocols to guide staff on when and how the medicines should be administered.

We checked the stock levels for people's medicines against stock records and found in some instances these did not tally. For example, one person's paracetamol stocks were recorded as 68, however there were only 61 tablets in the box. Another person's MAR recorded they had been given six paracetamol tablets on one day which meant they should have 94 tablets in the box, however we found the box still contained 100 tablets. In addition to the errors in the records we found that the keys to the medicines trollies were stored in a container immediately next to them. We were able to open the medicines trollies and cabinets without asking staff, which meant other people could have done the same. In addition we found items contained within the first aid boxes situated around the home were out of date. For example, a burn dressing had expired in January 2016, some bandages had expired in 2011 and 2016 and a body fluid spill kit expired in 2013.

Safe infection control practices were not followed. When we arrived we noticed the container outside the home which housed clinical waste was unlocked. We found that some communal bathrooms and toilets had no hand wash, no hand towels and no hot water. There was also no hot water in the kitchen. We spoke with the registered manager about the lack of hot water and were told it was because the boiler had not been switched on correctly by staff. However, we found that later on in the day there were still some sinks in communal bathrooms which lacked hot water. Staff told us they had different coloured mops for different areas of the home to prevent the spread of bacteria. However, we found that different coloured mop heads and handles were stored in contrasting coloured buckets. It was therefore not clear if mops designated for certain areas were used correctly. We spoke to a staff member about this who said, "It's okay, we use the right ones, we know what we're doing." In addition we observed the mops heads to be dirty and stored in such as a way that they were not dried between uses. The laundry room was untidy and soiled clothes had not been placed in the correct type of bag for washing. This meant there was a risk of clean items becoming contaminated with soiled items.

People lived in an environment that was not always clean and hygienic. There were strong odours of urine coming from two people's rooms. We entered one person's room where the smell was overwhelming. The

registered manager told us that this was a consequence of the behaviours the person displayed. They told us that the flooring in the room had been changed twice and acknowledged this needed to be done again. There was a blue mop bucket in the person's room and the mop head was dirty. The registered manager told us the person's room was mopped several times a day. However, as the mop remained in the person's room it was unclear how staff accessed hot water and appropriate cleaning materials to complete this task. The person's care records described the person's behaviour but did not give clear guidance to staff on how they should support the person to minimise the risks to their safety and well-being.

Systems were not in place to ensure people would continue to receive care in the event of an emergency. The home did not have a plan for what to do in the event of an emergency to ensure that people were kept safe and their care needs could be met. Records showed that fire drills were not completed at regular intervals with the last recorded drill being in April 2016. However, people had personal emergency evacuation plans (PEEPs) in place. These reflected people's needs and provided staff with information on how to best support them in the event of an emergency. Staff were able to describe to us the action they would take to evacuate the building and knew where fire exits and the external meeting point were located.

The failure to ensure people were kept safe from harm or risk, follow robust medicines management processes and provide a clean and hygienic service to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding concerns were not always acted upon and were not always reported to the local authority safeguarding team. During our inspection we reviewed accident and incident and care records. We identified a number of incidents relating to one person touching other people inappropriately. In addition, records described an incident where one person had hit another. This had not been reported to the local authority safeguarding team in order for them to ensure that appropriate action was taken to keep people safe. We spoke to the local authority following our inspection. They confirmed that no safeguarding referrals had been made by the home in relation to these issues and gave assurances they would look into these concerns. The registered manager told us that as the person's behaviours were known to the local authority they had not reported the incidents.

Staff were not fully aware of their responsibilities in relation to safeguarding people. Not all staff could identify a safeguarding situation. One staff member told us that if they saw one person hitting another they would not necessarily consider this a safeguarding incident. They told us, "Challenging behaviour I would report to the manager and she would handle the situation." However, when we discussed this further with the staff member they did tell us, "I would fill in a form, tell the manager and then she would tell social services." Staff were not able to tell us who they would report incidents to outside of the service and believed this was the responsibility of the registered manager.

The failure to identify, act upon and report safeguarding concerns is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may not always be cared for by a sufficient number of staff. We noted that one person required one to one staffing support throughout the day and staff confirmed this was the case. We were told by staff that this was provided by a trainee staff member two days a week and this was the case during our inspection. However on the other days, the support for the person came from within the staffing levels on the day. This meant that on five days a week there were two staff available to care for 16 people, many of whom required assistance with their mobility. We spoke to the registered manager about our concerns. They told us, "(Name) is not funded for one to one. I was going to speak to social services about it. We can't keep doing it." Following the inspection we spoke with the local authority who confirmed the person had moved from the

home.

We received mixed feedback from people and relatives about staffing. One person said, "The staff work very, very hard." A relative told us, "The staff are very good. However, the other day though there were only male staff on duty which is not so good if they are washing a female." Another said, "Staff seem to be extremely busy." Staff felt there was a sufficient number of them to care for people. One staff member told us they felt there was enough staff provided there were three on in the morning and three in the afternoon. They said, "The workload is manageable and we have more time in the afternoon." However another told us, "Sometimes we are a bit short and at those times we may have to leave the laundry because that can always be done by the night staff." They said that staff did not always have time to socialise with people. We saw occasions throughout the day when there was a lack of staff in the main lounge; this was especially noticeable during the morning when they were attending to people in their rooms with personal care. There were no staff in the lounge for a 30 minute period in the morning. One person in the lounge was showing signs of anxiety and shouted at others on several occasions. Another person was walking around without support. On two occasions we observed the person struggling to navigate the slope and door mat placed in the corridor and offered assistance.

The failure to follow ensure that sufficient staff are available at all times is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not hold evidence of all required checks on new staff that they recruited. This meant people may be at risk from being supported by staff who were not suitable. We reviewed the recruitment files for three staff members. We found that these all contained evidence of work history, a health declaration and a right to work in the UK. Each new recruit had also undergone a DBS check. The DBS is the Disclosure and Barring Service which helps to ensure prospective staff are suitable to care for people in this type of setting. However, we found two staff members did not have any evidence of references from previous employers. We spoke with the registered manager about this who was unable to find the documentation to demonstrate to us the references had been requested.

The failure to follow Schedule 3 is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were not always protected because staff did not always follow the principles of the MCA. Records for people did not contain evidence of decision-specific mental capacity assessments. We observed that people were subject to restrictions including a locked front door, sensor mats and continuous supervision. Although DoLS applications had been submitted they were not comprehensively completed to highlight these restrictions were in place.

Staff were able to describe the principles of the MCA but did not demonstrate their understanding in their job role. One staff member said, "We have to make decisions on their behalf." We asked them if this meant staff would just make decisions and they said, "No, there would have to be a meeting." Another staff member told us, "Dementia doesn't mean they don't have capacity and DoLS doesn't have to apply to everybody." However, we observed staff did not give people choice regarding when or where they ate or what drinks they would prefer.

The failure to follow the requirements of the Mental Capacity Act (MCA) 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not receive the training they required to support people's needs. The registered manager maintained a training matrix which detailed the training staff had completed. This showed that only two staff members had completed all training courses required by the provider. Of the 11 staff employed six had not completed infection control, fire safety, equality and diversity or health and safety training; four staff had not completed moving and handling or nutrition and hydration training. The registered manager told us they did not have systems in place to ensure that staff new to care completed the Care Certificate during their induction period. The Care Certificate is a nationally recognised set of standards for those working in the care sector. The concerns identified in relation to safeguarding, infection control and MCA demonstrated that staff did not have the skills required to fully understand the responsibilities of their job role.

Staff did not have the opportunity to meet with their line manager for supervision. One staff member said they had supervisions every three months and had an appraisal. However, records did not confirm this was the case. The supervision matrix identified that only three staff members had received supervision since April 2017. We spoke with the registered manager about this who confirmed this record was accurate. They

told us, "We're behind with supervisions. We've had trouble recruiting so have been helping on the floor which is the priority." This meant that staff's individual performance and skills were not being formally reviewed on a regular basis.

Failing to ensure that staff received training and supervision to support them in their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment that was not always homely or suitable for people's needs. Throughout the home there was a need for refurbishment and improvement to the décor. Many areas were tatty and looking tired. Skirting boards were badly scuffed and other paintwork was engrained with dirt. Two people did not have curtains in their rooms and a number of others were hanging down. The communal toilets downstairs were raised from the floor on a plinth. However, they had been raised so high they would be difficult for people to use. In addition, the layout of the toilets was extremely narrow which would make it very difficult for people to enter whilst using mobility aids. A number of bedrooms were sparsely decorated and contained few personal items. Some rooms were messy and had not been thoroughly cleaned for some time. In contrast, some people's rooms were personalised and individualised to their preferences. The design of the premises did not take into consideration the needs of people living with dementia. There were no areas of interest set up around the home to provide stimulation for people living with dementia. There were no names, pictures or photographs on people's bedroom doors to help them identify which was their room. There was a board displaying the day and time to help orientate people although we noted this had the wrong day displayed.

Areas of the home were not cleaned to a satisfactory standard. The floors in the hallways and dining area were sticky. Paintwork and sinks were dusty and there were strong malodours throughout the home. There were a large number of aerosol air fresheners placed in corridors, communal areas and people's rooms. We observed staff spraying these regularly through the day in an attempt to mask unpleasant odours. We asked one staff member if there was a cleaning schedule in place for them to follow. They told us, "No we're a small home we don't need that. If we see something is dirty we clean it." This demonstrated that the registered manager had failed to ensure that effective systems were in place to maintain the home to a good standard

The failure to ensure the premises were clean, properly maintained and suitable for the purpose for which they are being used was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects to the design of the home met people's needs. There were ramps in certain areas of the home to help ensure people could walk safely around the corridors. Those who lived on the middle and top floors could access their rooms via a lift.

People had access to a GP and other healthcare professionals although referrals were not always made in a timely way. One person was noted as requiring an eye sight test but there was no evidence that staff had arranged this. We spoke with the deputy manager who informed us that they would ensure this was arranged immediately. Another person's records from September 2017 stated that appointments with the chiropodist and dentist needed to be arranged but this had not been done. Other people's records showed they had access to a chiropodist, dentist and optician. A relative told us, "He is prone to urine infections, but I think the staff are very good at prompting him to drink more (to help avoid these)."

The failure to ensure people prompt access to healthcare professionals was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed reviews about the food that was prepared for them. One person told us, "The food is not bad. We have sandwiches or a meal. I can eat most things so I always give it a go." Another said, "The food is pretty good. We have to eat it, it's all we've got." However, a third said, "The food is sometimes very good. It comes and goes." Another person told us, "I'd say it's all right rather than good."

They told us that although staff encouraged people to get involved in the menu and make suggestions, these were not always taken into account by staff. We observed breakfast and lunch during our inspection. We found on both occasions staff acted in a task orientated way. They ensured people were served their food and drinks but did not take time to ensure people were comfortable and had everything they required. Breakfast was served at 9am although some people were up and dressed before this time. We heard one person ask for a drink at 08.40am. They were told that they would have one with breakfast in 20 minutes. Although people were not always offered a choice of drinks they were provided with refreshments at regular intervals throughout the day.

Staff were aware of people's specific dietary needs. One person required fork mashable food and the chef knew of this need. We saw this person received appropriately prepared food at lunch time. Staff encouraged people to eat foods appropriate to their health needs. One person was diabetic and a staff member told us, "[Name] likes sugary stuff. We try to encourage him not to have sugar in his tea, but it is his choice. He has capacity. We try to encourage everyone to eat healthily."

Inadequate

Is the service caring?

Our findings

People and relatives told us that they were supported by caring staff. One person told us, "They're (staff) very good here." A relative said, "She is cared for very well. People seem to be happy and staff seem nice. Everyone is very kind." Another told us, "She's looked after as well as she can be." Another relative told us, "I am quite happy. They (staff) look after him. He is always clean and nicely dressed. I think they are very caring here."

Despite these comments, we found people were not always provided with respectful, caring, person-centred care.

People were not shown respect or supported to make their own decisions and choices with regard to food and drinks. Throughout the day no one was given a choice of drink. There was no squash or fruit juice offered at breakfast and people were only given tea as a hot drink, there was no option for people to have coffee. One person told us their favourite drink was coffee but said they never got offered one. They told us, "It's always tea." Another person's care plan stated, 'nothing better than a hot sweet tea or coffee!' At the drinks round during the afternoon again everyone was given tea in mugs. These had been pre-poured and sugared in the kitchen and brought through on a tray. No one was offered an alternative and at lunchtime only orange squash was served, no one was offered a hot drink. We asked people if they were offered biscuits and one person told us they sometimes got offered biscuits, but not all the time.

At breakfast time there was a large saucepan of porridge brought into the dining room. The porridge was 'slopped' into bowls for people. The bowls were very small and we did not hear anyone being offered any more. Sugar was put on for people without asking if this was their preference. Where people were able to request an alternative cereal this was provided although no toast or cooked breakfast was offered. One person came down slightly later for breakfast by which time the trolley had been taken away. They were brought a mug of tea and a bowl of what they were told was porridge. They commented to the staff member, "It's not the usual is it? It's normally white." The staff member said, "Porridge, yes." The person tasted some and said it did not taste like porridge. We spoke with them and they said it tasted like liquid and was brown. We spoke with staff about this who told us they had given the person mashed Weetabix. Staff did make the person porridge as they had requested when we intervened.

The failure to ensure people had a choice of food and drinks was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity was not always respected as they did not always receive the support they required with their personal care needs. We spoke with one person who was in bed when we heard them asking for support. We observed the person was brought downstairs fully clothed eight minutes after the staff member had entered their room. The person looked unkempt and their hair had not been styled. We checked the person's room and found a wet sponge in their sink. However, their toothbrush was dry and had not been used. We went to another person's room who was up and dressed for the day. We noted that their teeth did not appear clean, their nails were dirty and their jumper was stained. There were no toiletries in their

bedroom and the basin was dusty and dry, indicating it had not been used. This was also the case in the communal bathroom. A third person's sink and soap was also dry and we could find no toothbrush in their room. All three people's care plans stated they required full support from staff with their personal care and the registered manager confirmed this. The majority of people living at Southlands only required staff to prompt them with their personal care. However, we observed that in general people did not appear well cared for and a number of people's rooms had extremely strong smells of body odour. There was no guidance to staff within people's care records as to how they should prompt and encourage personal hygiene.

People's privacy was not always respected. We observed three occasions when staff walked into people's rooms without knocking and other occasions when staff knocked but entered without waiting for a response. When walking back to the lounge after lunch one person was heard to shout, "I don't want to go back to my room." The staff member replied in a loud voice, "I'm not taking you back, I'm going to change your pad." On other occasions we observed staff knock on people's doors and approach them discreetly to offer support with personal care.

People's independence was not always promoted. When people required adapted equipment to support them to eat this was not available. A relative told us they had used a lipped plate at home for their family member. This information was also recorded in their care plan. They said they had noticed that staff were using an ordinary plate and the food was just coming off their family member's plate when they tried to eat independently. They had brought in a flan dish for the person to use and told us, "But, I don't know if they (staff) are using it." We noted at lunch time the flan dish was used. However, the person was given a knife and fork, rather than a spoon and fork to eat, consequently they were struggling. We spoke to a staff member regarding the use of adapted crockery and cutlery. They told us, "We don't have anything like that. Should we be getting some then?" We also noted staff had not cut up the person's food to further help them. The relative commented, "The staff aren't very good at cutting things up for her. You see, she is eating her fishcake whole."

The lack of respect shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas we observed people were able to maintain independence. People had the mobility aids they required to mobilise independently. A number of people accessed the community without the support of staff. One person told us they enjoyed doing this.

We observed some caring interactions between staff and people. Staff got down to people's eye level when speaking to them and used a caring and reassuring tone of voice. We saw some nice examples of kind, caring attention towards people from staff. During the afternoon staff were laughing together with one person. A staff member told us, "We use a sense of humour and help them as much as we can. We do things to please them." We observed the trainee staff member sitting with one person singing. When the person moved closer to them they put their arm around them so the person could rest their head on their shoulder.

Relatives told us that they were made to feel welcome when they visited and that staff maintained good communication with them. We saw relatives visited throughout the day and it was clear from the way staff greeted them they knew them well.

People's cultural needs were respected by staff. One person was a practising Christian and told us staff supported them to attend church services as often as they wished. In addition, their care plan clearly recorded their Christian values and how important it was for them to be able to read the Bible.

Requires Improvement

Is the service responsive?

Our findings

People did not always have access to activities to help prevent them feeling isolated. Although people and relatives told us activities did take place we found there was a lack of individualised, meaningful activities provided. We read people's daily records and these showed no activities of note. They mostly recorded people sitting 'socialising in the lounge' and 'watching TV'. One person told us, "We have people come in to us, but we never go out." A relative said, "That's the one thing. I haven't seen so much activities recently." The registered manager told us that people came in to do activities four afternoons a week including bingo, reflexology and music. The remaining time care staff were responsible for providing activities.

We did however see an activity in the lounge during the afternoon and there was a good atmosphere when an external activities person came to 'bake' with people. During the morning a staff member played a word game with people, however we were told that this staff member had actually come on duty to go out with one person which led us to believe this activity would not have taken place normally. Staff told us they felt more could be done with people. They said they had more time in the afternoon to socialise with people but also that activities needed to improve. A staff member told us there needed to be, "More communication with people." Another staff member told us, "We keep them occupied as much as we can. We have music, the hairdresser and they like the baking. [Name] and [name] go out shopping together and the men go to the pub." The people referenced were able to take part in these activities without the support of staff.

People may not always receive personalised care as staff did not know people's backgrounds well. We spoke with staff about people and they did not have a good background knowledge of them. One staff member did not know why one person who had lived in the home for a number of years had moved in or anything about their medical history. Another member of staff did not know anything about another person and said one person had moved in because, "Her daughter had her own stuff to do and she couldn't look after her anymore." We read this person's care plan and this was not the case. One person had a pre-admission assessment in their care plan, but this was for their previous service and not Southlands.

Although people's care plans reflected their needs and preferences the information recorded was not always reflective of people's current situation. One person's care plan stated they liked to 'go on walks and take public transport'. However staff told us they were no longer capable of taking public transport. This same person was recorded as requiring weighing every month as they had lost some weight, however the last recorded weight was in September 2017. One person had a history of behaviours that may cause them or others harm. However there was a lack of risk assessments around this, guidance for staff or information relating to what may trigger this type of behaviour. This same person was recorded as suffering from a mental and physical health condition but there was no further information or guidance for staff. Daily notes for people were written in a very task orientated way. For example standard phrases were used such as, 'fine, meals and meds taken, watching TV and socialising'.

The care people wanted when nearing the end of their lives was not known to staff. There was no information within people's records to show that their end of life wishes had been discussed with them. This meant that staff, family and healthcare professionals may not have the information required regarding

people's decisions and choices.

The lack of person-centred care shown to people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did however include information on their mobility, nutrition, sleep and communication. Some care plans recorded people's backgrounds and personal history. Where this was included it was detailed information. One person's care plan included photographs of them taking part in activities with external organisations.

Relative's told us that they knew how to raise any concerns they had. One relative said they would have no hesitation in talking to [registered manager] or staff and that, "I wouldn't put up with my sister not being looked after properly." Another told us, "If I had any concerns I would go to [registered manager]. They never mind. It's quite a well-run home." We asked staff what they would do if someone wished to complain. A staff member said, "I would go through the complaints procedure and ask someone to talk to the manager." The complaints policy was provided to people in their guide. These were given to each person when they moved into the home. Records showed there had been no complaints received since our last inspection and the registered manager confirmed this was the case.

Inadequate

Is the service well-led?

Our findings

Relatives told us that they got along with the registered manager. One relative said, "[Registered manager] is very nice. She comes down and has a chat." Another relative said of the registered manager, "She is very good."

The leadership of the service did not demonstrate clear values to ensure people received person centred care. Staff said they felt supported by senior management and the ethos of the service was made clear. One staff member said, "They really help. I feel valued and they (senior management) always take things into consideration. Everyone gets on well. It's like a family atmosphere." They said the ethos of Southlands was, "Always put the resident first and to treat them like a family member. Give them anything they need." They added, "The best thing we do is meet people's needs and their expectations." Another staff member told us, "The team is good. We help each other out." The registered manager echoed these comments from staff. They told us, "We are a family run business and try to avoid the place looking too clinical. We work alongside staff and address things in supervision. We do activities which help to create a homely feel."

Despite these comments we found that the positive ethos described by staff and the registered manager of putting people at the centre of the service were not embedded into practice.

The provider's website states 'The main philosophy of Southland is to provide and maintain a high quality of life within a warm, supportive, friendly and sensitive atmosphere where relationships between individuals will be affectionate and caring. It is the function of all involved to ensure at all times, that the dignity, privacy and the basic human right of self-respect of the individual is recognised and maintained in a safe environment. We further believe in a holistic approach in the care in our residents and value the customs and spiritual beliefs of the individuals. We found the service was not following this philosophy.

As reported we found that people were not given a choice regarding drinks and on some occasions, the meals they preferred. People did not always receive the support they required with their personal care. Risks to people's safety and well-being were not adequately addressed and people did not have access to activities to which met their needs and preferences. The environment was not cleaned to a satisfactory standard and many areas were in need of refurbishment. Although the registered manager told us that staff were supported through supervision, we found that staff did not receive on-going feedback on their performance as supervisions were not completed regularly. Although staff meetings took place they did not address any of the concerns identified during our inspection.

There was a lack of management oversight of the service. We spoke with the registered manager about the concerns we found during the inspection. They told us, "We have been short staffed and have had to work on the floor. We have concentrated on the foundations of the day-to-day running of shifts which means the paperwork has fallen behind. We are in a position now where we can start to catch up on things." They told us they were unaware of the concerns relating to people's choices and dignity not being respected. The registered manager said, "I've been in the office all day due to your inspection. If I'd been downstairs I would have seen it and spoken to staff."

However, it was clear that many of the practices observed were engrained into the culture of the service and had not been identified by the registered manager. The failure to identify these concerns and ensure improvements in the service were sustained meant people did not receive safe and effective care in line with their needs and preferences. We asked the registered manager if they sought support from external agencies or attended any local forums to gain support from other providers and registered managers. The registered manager told us they were aware that the forums existed but had not been able to find time to attend.

Quality assurance processes were not effective in identifying areas requiring improvement. The registered manager told us that following our inspection in July 2016 they had sourced support from an external agency to ensure that improvements were made. They told us, "We employed a consultant at great expense to put things right." Whilst it was evident that improvements had been made during our inspection in March 2017 these had not been sustained. Quality audits including care plan reviews, falls analysis, nutrition reporting and infection monitoring had not been completed since May 2017. No medicines audits had been completed between May and October 2017 and there was no evidence of infection control audits being completed. This meant that the systems implemented had not been sustained and that formal methods of assessing the quality of service people received were not routinely used. We asked the registered manager if there was a planned programme of maintenance in place. They told us that a staff member was employed to address day-to-day maintenance issues. However, there was no planned maintenance programme to ensure that the home was routinely decorated and maintained.

People's views regarding the running of the home were not always acted upon. Residents meetings took place which showed that people had said they were happy with the care provided. However, minutes from the meeting in September 2017 recorded that people had made suggestions which had not been implemented. People had requested toast and marmalade for breakfast and less frozen foods at meal times. We noted that people were not offered toast with their breakfast and the toad in the hole and fishcakes at lunchtime were both from the freezer rather than homemade. People had also requested that toilets be cleaned and re-stocked more frequently. Again, during our inspection we noted that there was no soap or handtowels in communal toilets and no cleaning schedule was in place to ensure they were cleaned regularly. People had also requested that the number of outings and trips were more frequent. There was no evidence to show that action had been taken regarding this request.

The failure to ensure good governance of the service was a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events. As reported there had been a number of incidents related to safeguarding concerns and two incidents where people had sustained significant injuries. Our records showed that the CQC had not been informed of these incidents to ensure that we were able to monitor the service provided effectively. We asked the provider to explain why these incidents had not been reported. They stated, "I wasn't really sure what I needed to report." When asked about an incident where one person had hit another person in the face the registered manager responded, "So every time we have an incident like this we have to report it?" This demonstrated the registered manager was not aware of their responsibilities as a registered person.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents You failed to submit statutory notifications in line with registration requirements.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people had prompt access to health care professionals. The provider had not ensured that people were provided with choices regarding their food and drinks. The provider had failed to ensure that people received person centred care and that activities were provided in line with their interests.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with dignity and respect at all times.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the

requirements of the Mental Capacity Act (MCA) 2005 were followed.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people were kept safe from harm or risk, follow robust medicines management processes and provide a clean and hygienic service to people

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to identify, act upon and report safeguarding concerns

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were clean, properly maintained and suitable for the purpose for which they are being used.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance You failed to ensure good governance of the service.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed You failed to ensure that robust recruitment checks were completed.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing You failed to ensure that sufficient staff were available at all times. You failed to ensure that staff received appropriate training and supervision to support them in their role.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration