Tamaris Healthcare (England) Limited

Southfield Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Southfield Court Care Home is a nursing home providing accommodation for up to 50 people, who require personal care. The service provides support to people who have physical health needs and conditions such as dementia. At the time of our inspection there were 34 people using the service.

The home is set out across 2 floors, each with a communal lounge and dining area.

People's experience of using this service and what we found
We found people were at risk of harm as medicines and risks associated with people's care were not always safely managed. Risks to people and incidents were not always identified, communicated with other staff, or reviewed to ensure safe and effective care.

Staff were not always appropriately trained to meet the needs of people and feedback about how staff were support varied. Feedback from staff suggested staffing levels were not always in line with people's needs. We found the service was not using its governance processes effectively to review staffing levels or people's support needs. We found evidence of good partnership working with other health and social care professionals.

The premises was generally clean. However, we found it was not suitable for the needs of people using the service, particularly people diagnosed with dementia and had strong odours throughout.

People and their relatives told us they felt the care provided was safe. Staff were trained in safeguarding and some staff could give examples of different types of abuse. People and relatives mostly spoke positively about the care provided by staff, and we saw some positive interactions between staff and people. Recruitment was managed safely, although records associated with recruitment needed reviewing to ensure the most up to date information was available.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, we found conditions relating to people's Deprivation of Liberty Safeguards (DoLS) were not always actioned in a timely manner.

There was an interim manager at the service as the registered manager was not present. The interim manager was working to address shortfalls in practice and improve governance oversight. The interim manager and regional manager were responsive to our inspection findings, and we received updates about what actions they were taking to address concerns.

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

The last rating for this service was good (published 06 October 2022). At our last inspection we recommended the provider reviewed medicines records and took action to update their practice. At this inspection the provider had not addressed this. We also made further recommendations in the responsive domain; this domain was not looked at as part of this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about poor recording, staffing levels, incident management, management oversight, training and nutrition and hydration. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care, medicines, staff training and support, person-centred care, and good governance. Please see the action we have told the provider to take at the end of this report.

We have made a recommendation about infection, prevention, and control practices.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Southfield Court 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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector, 1 specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Southfield Court 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 Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post. However, the registered manager was not present during the inspection, and an interim manager had been assigned to oversee the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had received about the service since its last inspection in 2022. We requested feedback from stakeholders, including local safeguarding, infection control and commissioning teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service and 4 relatives about their experience of care provided. We gathered feedback from 7 staff members including the interim manager, the regional manager, the clinical lead, and care staff. We looked around the building and observed people being supported.

We reviewed a range of records including 8 people's care plans and risk assessments. We reviewed a variety of medicines records. We looked at 4 staff files in relation to recruitment and a sample of agency staff recruitment profiles. We reviewed records relating to the management of the service, including health and safety records and audits.

We had a meeting with the interim manager and the regional manager during the inspection to discuss queries in relation to safe care, good governance, and staffing. We requested additional evidence, including training and incident records and policies following the site visit.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Staffing and recruitment; Learning lessons when things go wrong

- Risks associated with people's care were not always assessed, reviewed, or recorded correctly. Pre-admission assessments were not always completed or available to determine people's care and support needs and inform care planning.
- Incidents and accidents were not always regularly reviewed to mitigate future risk to people. For example, there had been 41 unwitnessed falls in a three-month period, although individual falls had been reviewed, the high number of falls or staffing levels had not been reviewed to prevent future risk.
- Feedback from staff suggested staffing was not in line with people's needs. One staff member said, "We need more staff as people are dependent on us". The provider was using high levels of agency staff, particularly registered nurses.
- Staff told us they knew how to report incidents. However, we found incidents were not always communicated with other staff or management in a timely manner and recorded appropriately.
- Systems and processes in place were not being used effectively to learn lessons when things go wrong. Where repeated concerns had been identified, these were not always acted upon. For example, wound management audits identified on-going assessments of wounds were not always completed.

Systems were either not in place or robust enough to demonstrate safe care. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider was actively recruitment permanent members of staff, and the interim manager was working to address governance oversight.

- Records associated with the health and safety of the building were in date and regular health and safety checks were taking place.
- Recruitment was safely managed. The interim manager was reviewing recruitment records during the inspection, to ensure the relevant information was available in staff's files.

Using medicines safely

At the last inspection we recommended the provider reviewed people's medicines records and considered current guidance on variable dosage medicines. The provider had not addressed all areas of this recommendation.

● Medicines were not always managed safely, which placed people at the risk of harm. We found one person's cream stored in a laundry cupboard.
● Care staff were administering thickening agents in people's drinks. We requested and did not receive evidence care staff had been trained in the administration of this. We found no evidence of impact on people.
● People's 'as and when' medicine records had not always been reviewed in a timely manner.

People's medicines were not always managed in a safe way. This placed people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The clinical lead and interim manager were actively working to embed better practices around medicines and had addressed poor medicines practice with relevant staff.

● The provider had multiple policies to support staff in the administration of medicines and the service was working with other health and social care professionals to inform good medicines practice.
● Controlled drugs were managed safely.

Preventing and controlling infection
●. The home was generally clean and tidy. However, there were strong odours throughout the building. The service had domestic staff to support infection, prevention, and control.
● Cleaning schedules were being completed by domestic staff to evidence their work. However, records indicated that tasks could not always be completed as domestic staff were supporting people with care.
● The providers infection prevention and control policy was not in date.

We recommend the provider reviews their infection prevention and control processes and associated records.

Visiting in care homes
The provider's approach to visitors in the care home was in line with current government guidance and people were supported to have visitors.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to protect people from the risk of abuse.
● People and relatives felt the care provided was safe. One person said, "I feel safe here, I just do."
● Staff had received safeguarding training and most staff could give examples of different types of abuse. All staff told us they would report any safeguarding concerns to the management team.
● The provider had a safeguarding and whistleblowing policy which was accessible to staff.

Requires Improvement

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were not always appropriately trained in line with the needs of people at the service. For example, people at the service experienced seizures and care staff had not received training on how to support this. We found no evidence of impact on people.
- Staff training compliance was not in line with the providers requirements. The interim manager was working to increase training compliance.
- Feedback from staff varied regarding the support they received. Most staff told us they had not received a recent supervision. The supervision tracker for the service showed staff supervisions had not been completed as scheduled.

Staff were not always trained or supported to meet the needs of people using the service. This was a breach of regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager arranged additional training following the inspection due to the concerns raised by us and said they would review their supervision schedule.

- All staff said they would feeling comfortable raising concerns to the management team.

Adapting service, design, decoration to meet people's needs; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- The service provided support to people living with dementia. The design and decoration of the home was not suitable for the needs of these people. People's bedrooms were not easily identifiable to them, and information displayed was not in an accessible format.
- The dining experience was not suitable for the needs of people. People were not encouraged to sit in communal areas and engage in a dining experience. This had been repeatedly identified in audits. However, actions identified to improve this had not been effectively implemented.
- People's support needs relating to nutrition and hydration were not always appropriately managed. For example, one person's care plan stated they were to sit upright when eating. However, we observed them eating in a recliner chair. Another person's care plan stated they 'pouched' food, but we saw no evidence of a referral to the relevant professionals.

The care and treatment of people was not always provided in a person-centred way. This was a breach of regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager and regional manager acknowledged the service design and dining experience was something which needed improving. The interim manager had already begun a review of people's nutritional and hydrational needs prior to our inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Most people's needs were assessed prior to receiving care. However, some assessments had not been completed or there was no information available to evidence this.
- Some care records were not person-centred. Most staff told us they had not read people's care plans or risk assessments as they did not have time.
- Care records were regularly audited. However, actions were not always taken to address concerns identified with care planning. The interim manager began a review of care records during the inspection.
- The home worked in partnership with other professionals to ensure people received effective care, such as GP's, district nurses and mental health teams.

Please see the safe and well-led section of this report for action we have taken.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Conditions associated with people's DoLS had not been implemented in a timely manner. The interim manager completed a review of this during the inspection and took appropriate action.
- Systems and processes were in place to ensure people consented to their care. Mental capacity assessment had been completed and best interest decisions had taken place where appropriate.
- We observed interactions between staff and people where people were asked for their consent.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The registered manager was not present at the time of inspection, and an interim manager had been in post for 4 days. The registered manager had not had appropriate oversight or taken action to address concerns identified at the service.
- Poor recording and governance processes meant the service could not always evidence how they promoted a person-centred culture.
- The provider was not using its quality assurance processes effectively to continuously learn and improve care. Audits over a six-month period identified repeated concerns, and action was not always taken to address these.

Systems and process were not robust to ensure good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager and regional manager responded during and after the inspection and confirmed they were working to increase governance oversight and compliance.

- The interim manager understood their regulatory responsibilities and had created an action plan to address concerns identified prior to and during the inspection, this practice needed embedding. The clinical lead evidenced they wanted to improve the culture and practice.

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

- Surveys and meetings for people and relatives had not routinely been completed. Where surveys had been completed, issues raised had not always been addressed.
- The interim manager understood their responsibilities in relation to duty of candour and notified families when things went wrong. However, we found responses to information of concern to CQC, and other bodies were not always completed in a timely manner by the registered manager.
- Staff meetings were taking place and some staff told us they found these helpful. One staff member said,

"We get to discuss everything that needs doing, they are helpful".

● The service was generally working proactively and in partnership with other health and social care professionals to ensure people received appropriate and effective care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of people was not always provided in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines and risks associated with people's care were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance processes were not robust or being used effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always appropriately trained or supported to provide safe and effective care.