Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
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Bradford
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Southfield Care Home is a residential care home providing accommodation and personal care to people aged 65 and over. At the time of the inspection there were 27 people living at the home. The service can support up to 54 people.

People's experience of using this service and what we found
During our inspection visits in December 2020 and April 2021 we found people did not receive safe care. At this inspection we found the provider had made some improvements, but people continued to be at risk of harm. There was a lack of detailed risk assessments and guidance for staff in relation to people's individual risks and support needs. Some care records contained inconsistent and inaccurate information. Medicines were not managed safely. People were not always protected from abuse and neglect. Government guidance on infection, prevention and control was not always followed.

The home was not always well-led. There was no registered manager and there had been numerous management changes. The provider had made some improvements to how quality checks were carried out. However, audits were not completed consistently, and they failed to identify the repeated shortfalls we found at this inspection. Opportunities to learn lessons and make improvements to the home had not been taken.

Changes at the home meant people lived in a comfortable and clean environment. The provider had made a range of improvements to people's bedrooms and communal and garden areas.

Staffing levels had increased, and this meant people received support when they needed it. People were generally supported by staff who knew them well. Recruitment was managed safely.

People and relatives told us they felt safe living at Southfield Care Home and staff were kind and caring.

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 May 2021). The provider completed an action plan after the last inspection to show what they would do and to improve and by when. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 21 January 2021.

Why we inspected
This was a planned inspection based on the previous rating.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, risk management, safeguarding people from abuse and good governance at this inspection.

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 until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service 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 six 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 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 Care Act 2014.

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

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

Service and service type
Southfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We observed care and support in communal areas. We spoke with six people who used the service and two relatives about their experience of the care provided. We spoke with ten members of staff including the provider, managers, a team leader, senior care workers and care workers. We also spoke with a health care professional.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated inadequate. At this inspection this key question has stayed the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people's safety were not always assessed and care plans lacked detail and contained contradictory information. Risks relating to people's mobility, skin integrity and mental health were not assessed and monitored effectively. For example, one person regularly became anxious and upset. Records showed they displayed some behaviours that exposed other people to the risk of harm. There was no detailed risk assessment to advise staff how to support them safely and consistently.
● People's nutritional needs were not being met and they were at an increased risk of malnutrition. For example, one person had lost over 8kg in weight since September 2021. Their nutritional care plan and risk assessments had not been updated to reflect this and the person's meal records showed they were having a low dietary intake. Not all staff were aware the person was losing weight.
● Government guidance on the prevention and control of infection was not always followed. We observed multiple occasions where staff were not wearing masks correctly. Not all staff were bare below the elbow. Staff were wearing long sleeves and jewellery, which contravenes best practice.
● Routine safety and environmental checks were in place. However, radiators and mobile heaters in parts of the home were very hot to the touch. Risk assessments were in place but were not being followed. We discussed this with the provider, and we were assured they would take action.
● People's care plans were not always reviewed after serious events. Lessons were not learned when things went wrong. There had been improvements in how accidents and incidents were recorded but there was no evidence of management reviews or oversight.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements had been made to the cleaning schedules and the environment was clean and tidy. Rotas had been reviewed to ensure there was increased availability of ancillary staff.
● We were assured staff and people were accessing COVID-19 testing and systems were in place to check

professional visitor's vaccination status.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely

At our last inspection the systems were not robust enough to demonstrate medicines were managed effectively. This was a breach of regulation 12 (Safe care and treatment) 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 managed safely.
● Some people were prescribed medicines to be taken 'when required' or as a variable dose. There was a lack of detailed guidance to direct staff how and when 'as required' medicines were administered and there was limited information recorded when these medicines had been administered. This meant there was a risk people did not receive their medicines consistently or when they needed it.
● Guidance and records were not always in place to support the safe administration of topical medicines including creams and patches. For example, guidance about how and where creams should be applied was not clear and there were gaps in records. Patch application records were sometimes incomplete therefore there was no assurance they were rotated in line with manufacturers guidance.
● Medicines for two people were not available when the monthly medicines were delivered.
● We were not assured people received their medicines in a timely way. For example, on the day of the inspection one person repeatedly requested pain relief from staff for more than two hours. This was not offered to them as the senior on duty was administering medicines in a set order. We raised this at the time with the provider.
●Staff had received training to administer medicines. The manager told us staff's competency to administer medicines had been assessed. However, the records were not available
● Medicines audits were in place, but they were not effective and did not provide assurances medicines were managed safely. They had not identified the repeated shortfalls found at this inspection.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider demonstrated staff had their competency to administer medicines re-assessed by the community pharmacist. Updated systems had been introduced to ensure the safe administration of creams.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the systems were not robust enough to ensure people were protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 13.

● Systems were not in place to ensure people were protected from abuse and neglect.
● Systems were not in place to ensure people's finances were managed safely. The provider had a policy for supporting people with their finances. However, this lacked detail and was not being followed. There were some financial checks in place but a lack of comprehensive management oversight. For example, two people kept large amounts of money in their rooms. However, there were no risk assessments in place or lockable facilities available to them.
● Records showed staff had not received up to date safeguarding training. The training matrix showed 11 out of 25 staff had not received training. This included one of the managers of the service.

Systems were either not in place or robust enough to demonstrate people were safeguarded from the risk of abuse. This placed people at risk of harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people and relatives told us they felt safe living at the home. One person said, "The staff are good. They do everything we want them to do. I feel safe because they look after you."
● Staff were able to describe different forms of abuse and how they would respond and report this.

Staffing

At our last inspection the provider had failed to demonstrate there were enough suitably qualified, competent and experienced staff always deployed to meet people's needs. This was a breach of regulation 18 (Staffing) 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 18.

● Most people and relatives said there were enough staff to provide care and support. One person said, "I feel safe as there are people about. The staff are very nice. I have no qualms they are obliging." A relative said, "[Person] is happier now. There seems to be enough staff. [Person] is safe here."
● Staffing levels had increased during the day and night since our last inspection. We observed staff were available to people. The provider had developed a dependency tool and they used this to assess how many staff were required.
● Staff told us the increased staffing levels had a positive impact on people who lived at Southfield. They said they were able to respond promptly when people needed care, support or comfort and they had more time to talk with people. One staff member said, "It's running smoother now there is more staff. There is always someone there to give reassurance and help. I think the changes mean people feel more safe and secure."

Recruitment

At our last inspection the provider had failed to demonstrate robust recruitment processes were in place to ensure people were protected from the risks associated with the employment of unsuitable staff. This was a breach of regulation 19 (Fit and proper persons employed) 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, and the required checks were in place before staff started their employment.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to robustly establish systems to assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 (Good governance) 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.

● At the last two inspections we identified multiple breaches of regulation. Significant shortfalls were also found at this inspection. Systems should have been in place to ensure the provider was aware of how the service was operating and to ensure compliance with regulations. This meant we were not assured the registered provider and managers understood regulatory requirements and the importance of quality improvement.
● Audits were in place, but they were generally completed by senior staff and there was no effective management oversight. The shortfalls we identified in previous inspections relating to the management of risk, medicines and good governance had not been addressed and we identified similar issues and concerns.
● There was a lack of strong and effective leadership. The home had not had a registered manager since February 2020. A manager had joined the service in April 2021, but they had left in November 2021. The provider had recently recruited a new manager and the deputy manager had been promoted.The provider told us two managers had commenced their application to be jointly registered with the Commission.
● Records of people's care and support were not adequately kept. There was no robust system for assessing and managing risk to people's health and safety. This meant people were at an increased risk of injury or their health and well-being deteriorating. Records relating to people's care were not always accurate and up to date.
● Policies were in place, but they had not been reviewed to include best practice. Guidance for ensuring a safe quality service was not always followed. For example, the provider had a policy for managing people's finances, but this lacked detail and was not followed.

We found no evidence that people had been harmed. However, systems were either not in place or robust

enough to demonstrate governance processes were effective. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider told us one of the managers would be taking on the role of overseeing all audits. They also planned to introduce weekly recorded provider visits.
● The manager had complied with the requirement to notify CQC of various incidents so we could monitor events happening at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback about people's experiences. Some people and relatives expressed their satisfaction with the service and commented on the recent improvements they had seen. There was mixed feedback about the management of the home and changes in management arrangements. One person said, "I don't know who the manager is. They are always changing."
● Staff told us Southfield had not always been well-led and commented on the negative impact of frequent management changes. One staff member said, "When there are different managers you don't know what is going on." However, staff consistently said they had confidence in the current managers. They said they were approachable and fair. One staff member said, "I feel able to bring things up and it is dealt with straight away now."
● Staff worked well together and demonstrated teamwork. There were regular daily and team meetings.

Working in partnership with others
● After the last inspection the provider had received extensive input from local authority partners and had worked closely with them.
● The service worked in close partnership with health care professionals. One health care professional commented on the improvements at the service. They said there were always staff available to support their visits. They said, "The home is definitely a lot more positive and settled. We work well together."