Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
Great Horton
Bradford
West Yorkshire
BD7 3LF

Tel: 01274521944

Date of inspection visit:
10 March 2022
17 March 2022

Date of publication:
21 April 2022

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 for up to 54 people aged 65 and over. At the time of the inspection there were 24 people living at the home. Southfield Care Home accommodates people in one adapted building over two floors. At the time of the inspection people were all living on the ground floor.

People's experience of using this service and what we found
Despite highlighting shortfalls at the last three inspections, the provider had failed to take enough action and people continued to be at risk of harm and poor care.

The provider was unable to demonstrate robust governance arrangements and learning had not taken place. Systems and processes designed to identify shortfalls and drive improvement were not effective and had not identified the concerns we found. Significant shortfalls identified at the last inspection had not been addressed. The provider did not demonstrate they understood their legal responsibilities.

The provider had not complied with their lawful duties to display their current inspection rating at the service and on their website.

People did not always receive their medicines in a safe way. Specific issues we had raised at the last inspection concerning the management of medicines had not been addressed. The systems in place and management oversight had failed to identify the repeated shortfalls.

The provider had not assessed and mitigated the risks to people, and people did not have an accurate and complete care record. This included hazards in the home's living environment as well as risks associated with people's health, safety and wellbeing. Procedures failed to safeguard people from the risk of abuse.

Safe recruitment practises were not followed as the required background checks had not been undertaken before staff started work at the home.

Most people and relatives told us they felt safe and there were enough staff to meet people's needs. Staff were kind, respectful and caring and we observed warm and friendly interactions between people.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 14 January 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

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

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

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 safeguarding, safe care and treatment, medicines, staff recruitment and good governance.

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 return 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 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 first day of 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. The second day of the inspection was carried out by two inspectors.

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. A registered manager along with the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager and deputy manager based at the home. The manager had commenced their application to register with CQC.

Notice of inspection
This inspection was unannounced on both days.

What we did before the 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. The provider was not asked to complete a provider information return prior to the inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with seven members of staff including the nominated individual, manager, team leader and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We held a meeting with nominated individual and the manager after the site visits to discuss the management of the service.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including audits and policies.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested additional evidence and documentation from the provider that was not available on the day of the inspection and we reviewed this. Where we had concerns about people, we made referrals to the local safeguarding authority.

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 as inadequate. The rating for this key question has remained inadequate.
This meant people were not safe and were at risk of avoidable harm.

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 always managed safely. Multiple issues we had raised at the last inspection had not been addressed.
● We checked medicines stocks and they did not always reflect what was recorded on the medication administration records. This meant we could not be assured they had been administered as prescribed.
● Guidance and records were not in place to support the safe administration of topical medicines including creams and patches. Since the last inspection the provider had introduced a dedicated medicines trolley for creams. Guidance was missing to show where creams should be applied and there were gaps in administration records. Patch application records applied for pain were incomplete, and records did not show that patches were applied and rotated along with manufacturer's guidance to reduce side effects. At the last two inspections we raised concerns about creams not being stored safely. At this inspection we saw creams continued to be left on shelves in people's rooms. This included one cream which should have been stored in the fridge.
● Some people were prescribed medicines to be taken on a 'when required' basis or with a variable dose. Guidance for staff was missing on how these medicines should be administered. Where 'as required' medicines were administered, records were not always completed to show why they were given. This meant there was a risk people did not receive their medicines consistently or when they needed them. The provider told us they were in the process of preparing new guidance.
● Fluid thickener, to thicken a person's drink to aid safe swallowing, was not recorded when it was used. We could not be assured this was being used safely.
● Staff carried out medicines related audits, but they failed to identify the concerns we found during the inspection. The provider had a medication policy. However, this was not in line with good practice guidance and some areas were not relevant to the care home setting. We told the provider about our concerns after the first day of the inspection and they told us the issues would be addressed.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and

welfare of people. This was a breach of regulation 12 (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.

● People were at risk of harm because risks had not been adequately assessed and monitored. The issues we raised had been identified at previous inspections. Lessons had not been learned and action had not been taken.
● At the last two inspections we found heated towel rails in people's en suite bathrooms were extremely hot. On the first day of this inspection, we saw heated towel rails in two people's bathrooms continued to pose a risk of burning to vulnerable people. We discussed this with the provider on the first day of the inspection and they told us the management team had been discussing what action to take. On the second day of the inspection the towel rails had been turned off.
● Risks relating to people's skin integrity, mobility, nutrition and hydration and mental health were not assessed and monitored effectively. We reviewed 11 people's care records and found shortfalls in them all. There was strong reliance on staff being updated verbally. This was not always effective and meant vulnerable people were at an increased risk of harm.
● One person had been assessed by a health professional as needing a specialist diet and thickened fluids. There was no information in their eating and drinking risk assessment about this. On both days of the inspection we spoke to care staff and they were unclear about the person's needs. This meant we were not assured their drinks were offered at the correct consistency and the person was at risk of harm.
● Where people experienced periods of distress and anxiety which posed a risk to other people, assessments did not provide clear and up to date information. Incidents were recorded by staff, but this was not used to inform care plans and develop a consistent approach. For example, records showed that one person had recently pushed and hit people, pulled hair and thrown items. Their risk assessment stated the person was aggressive and known to attack people. There were no further details recorded or guidance to staff about how to support the person consistently.
● Where people required support with moving and handling, assessments had not been fully completed and contained contradictory information. For example, one person's assessment stated they needed a hoist and a moving and handling belt. It was not clear if the person was able to weight bear. We were not assured staff were moving and handling people safely as they did not have the information they required.
● Routine safety and environmental checks were not consistently in place. Buildings checks were not robust and maintenance issues were not followed up promptly. On the first day of the inspection, we saw three bathrooms with broken toilet flushes. In another person's bedroom there was a double plug socket with several cracks in it, partially covered with tape. These issues had not been rectified on the second day of the inspection.
● Accidents and incidents were recorded, but the information was often not fully completed and provided a limited overview of what had happened. There was a lack of information about what action had been taken to prevent a reoccurrence. For example, one person had recently fallen out of bed. Their risk assessments had been reviewed since the incident, but the fall risk was not considered and there were no changes made to prevent a reoccurrence. We sought assurance from the provider these issues would be addressed.

We found systems were either not in place or robust enough to demonstrate medicines were managed safely and risks to people's health and safety were 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.

Systems and processes to safeguard people from the risk of abuse

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

● The provider's procedures failed to safeguard people from the risk of abuse.
● During the inspection, a safeguarding event had taken place between two people living at the home which resulted in one person sustaining harm. We spoke with four staff and found they were not aware of the incident. On the second day of the inspection we reviewed the person's risk assessments and no updates had been made to reflect what had happened.
● Other records showed potential incidents of abuse had happened which had not been referred to the relevant authorities. For example, there were two recorded incidents where different people had been hit by other people living at the home. This meant there was no monitoring or oversight from external bodies.
● We identified reports of service users having injuries when the cause was unknown. There was no evidence of a follow up investigation or a referral to the relevant safeguarding authority. Unexplained injuries were not investigated to establish if there were signs of abuse. This meant we were not assured service users were protected from the risk of injury or harm from abuse. We have made referrals to the local safeguarding authority.

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

● People and relatives told us they felt safe living at the home. One person said, "I feel safe because I know everyone, and we all know each other." A relative said, "I think [person] is safe because incidents are managed well. I have no concerns about [person's] care at all."
● Staff had received safeguarding training. They were able to describe different forms of abuse.

Staffing and recruitment
● Safe recruitment practises were not followed. The required employment checks to ensure individuals were suitable to work with people had not been completed. We requested staff recruitment records after the inspection. We did not receive these. We were not assured staff were recruited safely.

We found no evidence that people had been harmed. However, systems were not in place to ensure that staff were recruited safely. This put people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us there were enough staff to support people. One relative said, "There is always plenty of staff around. They are always on the go. There's a good atmosphere with the residents."
● Staffing levels were calculated using a dependency tool. The provider reviewed this regularly to ensure there were enough staff on duty to meet people's needs.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rule.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were somewhat assured that the provider's infection prevention and control policy was up to date.

The provider was supporting relatives and friends to visit people safely. Relatives confirmed they were offered personal protective equipment and arrangements were in place for them to complete a lateral flow test before coming into the service.

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. The rating for this key question has remained inadequate.
This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

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.

● Significant shortfalls had been identified at the last three inspections. We found continued breaches of regulations relating to medicines, the management of risk, safeguarding and good governance. We also a found a new regulatory breach relating to the safe recruitment of staff. Shortfalls included specific concerns which had been raised at the previous inspection. For example, we shared details of concerns about the lack of information in one person's eating and drinking care plan after the last inspection. We reviewed this person's care records again and no changes had been made.
● We were not assured the registered provider understood regulatory requirements and the importance of quality improvement.
● Registered providers are legally obliged to inform the Care Quality Commission (CQC) of certain incidents which have occurred in the home. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. Notifications about some significant events had not been submitted to CQC. The provider did not always report allegations of abuse. This meant they did not fulfil their legal responsibility.
● There was a lack of strong and effective leadership. There had not been a registered manager at the service since January 2020. Since then, there had been three managers at the home but none of them had registered with CQC. The manager had completed their application to register with the Commission.
● There continued to be a lack of robust systems for managing risks to people's health and safety. This meant people were at heightened risk of injury and their health and wellbeing deteriorating. Records relating to people's care were not always accurate and up to date.
● Since the last inspection the provider had introduced closed-circuit television (CCTV) in the communal areas and corridors of the home. There were large television screens in two lounges which showed the movements of people, staff and visitors around the home. We discussed this with the provider, and they said

the system was not fully operational. There was no signage displayed to tell visitors CCTV was in place. We were not assured the provider had completed a robust assessment of the safe and appropriate use of CCTV, considering the equality and human rights of people who used the service.

The above evidence demonstrated that people were placed at the continued risk of harm through the lack of effective governance systems. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider was unable to demonstrate they understood and acted on their duty of candour responsibilities. They had not addressed issues raised at the last inspection.

● The provider did not always provide information in a timely way. For example, on the second day of the inspection we were not able to review some records including staff recruitment files as the manager did not have access to them. They confirmed they would send them remotely the next day. We did not receive them.

● Providers must ensure their rating is displayed conspicuously and legibly at the location. On the first of the inspection we saw the rating from the last inspection was not displayed in the home or on the provider's public website. We asked the provider to ensure their most recent rating was displayed. On the second day of the inspection the correct rating was displayed. However, the provider's website had not been amended.

This was a breach of Regulation 20(A) Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider could not demonstrate continuous learning and improvement. The significant shortfalls identified at the last three inspections had not been addressed. The service had been supported by the local authority and a consultant to improve standards. However, during the inspection we found there was a failure to make the necessary improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People's care records were not always up to date, or person centred. They did not contain individualised information and people had not been involved in their care planning. The manager told us they had updated people's care plans, but this was not apparent in people's care records when we inspected.

● We received mixed feedback from relatives about the management of the home. They expressed concern about the number of management changes that had taken place, but most relatives spoke positively about the manager. One relative said, "The new manager is very friendly and nice and makes times to talk to you." Another relative said they were concerned about not being informed about changes and only found out there was a new manager when they visited. The provider circulated monthly newsletters to relatives.

● Since the last inspection the provider had employed an activities coordinator. Staff, people and relatives spoke positively about how this impacted on people's wellbeing and social opportunities. We saw people being engaged in a craft activity. The atmosphere was lively, and people were enjoying taking part and engaged warmly with each other and staff. One staff member said, "There are a lot more activities now. People are more involved, and they enjoy it."

● The provider had conducted a survey with people who lived at the home. Feedback was generally positive

and where people had raised issues, action had been taken. For example, one person had requested a change of bedroom and staff supported them to move bedrooms.

● Staff worked well together and demonstrated teamwork. They all spoke positively about the support they received from the manager. They said they were visible and accessible. One staff member said, "You can always ask for help. [Manager] finds a way of making it good."

● The provider was working closely with a consultant. They had developed a Service Improvement Plan.

● Records showed staff engaged with a range of health and social care professionals.