Northamptonshire County Council

Southfields House

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 caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Southfields House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Southfields House is located in Northampton and is registered to provide accommodation and personal care to older people. It provides care for older people and people with a physical disability and accommodates 45 people across six separate units, each of which have separate adapted facilities.

The provider had recently started to provide reablement support to people for up to six weeks following discharge from hospital. When we visited there were 23 people living at the home permanently and nine people temporarily living at the home receiving reablement support.

The reablement support was being provided in two areas, separately to people that lived at the home permanently to minimise any disruption. However, the provider told us that they were planning to increase the number of reablement beds available and extend this to a third unit. The provider was in the process of consulting with people and their relatives regarding this change.

This is Southfield House's first comprehensive inspection under the current provider. The inspection took place on the 12 November 2018 and was unannounced.

The provider notified us that the registered manager was absent from work. 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. The provider had appointed an acting manager as an interim arrangement.
People were at risk of not receiving a nutritionally balanced meal or adequate nutrition as a menu was not being followed and there were inconsistencies in the kitchen staff. This impacted on the quality and the variety of food available to people.

We found the poor cleanliness of the kitchen and unsafe food storage had not been adequately addressed by the management team, despite this being identified in meeting minutes and audits two months prior to the inspection.

Risk assessments were in place but did not always include enough information to assist staff in identifying a deterioration in people's health condition.

Some people at the home were prescribed medicines on a when required basis. We found there was no guidance in place to advise staff when and how to give these medicines.

People were at risk of accidents or incidents re-occurring as reports were not immediately reviewed to identify learning. This meant changes were not promptly made to reduce the risk of the incident occurring again.

The quality assurance systems in place identified areas that needed improving. The acting manager had developed an improvement plan to enable the service to prioritise areas for action. Whilst we found the acting manager had implemented improvements that impacted positively on people, further improvements were required and we could not be assured these would be sustained or were embedded in practice.

People were treated with warmth and kindness by the staff and management team, and supported by staff that had taken time to get to know them and enjoyed spending time with them. People's privacy and dignity was protected and promoted always.

People were assisted to maintain relationships with their families, visitors were welcome at any time and were made to feel at home.

People told us they felt safe and staff understood their roles and responsibilities to safeguard people from the risk of harm. There were sufficient staff available to meet people's needs and staff had been safely recruited.

People using the service and their relatives knew how to raise a concern or make a complaint and felt confident these would be addressed.

People were supported to access relevant health and social care professionals and there were systems in place to manage medicines safely. People received their medicines as prescribed.

People were supported by staff that had the skills and knowledge to meet their needs. Staff received effective and regular supervisions and appraisals to enable them to carry out their roles effectively.

At this inspection, we found the service to be in breach of one regulation of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

Further information is in the detailed findings below.

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.

The provider had not ensured that people were protected from the risks of unsafe food handling and kitchen cleanliness.

Risk assessments did not always detail information for staff to identify signs of health deterioration.

People received their medicines as prescribed and were supported by staff that had a good understanding of safeguarding procedures.

Some people at the home were prescribed medicines on a when required basis. We found there was no guidance in place to advise staff when and how to give these medicines.

Accident and incident reporting did not identify any remedial actions that needed to take place to minimise the reoccurrence of the incident.

Is the service effective?

Requires Improvement

The service was not always effective.

People were at risk of not receiving a nutritionally balanced diet or receiving enough fluids to keep them hydrated.

Best interest assessments were not always completed as required by the Mental Capacity Act 2005.

People were supported to live healthier lives and maintain good health by attending regular health checks and medical appointments.

People received care from staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and compassion.

People's privacy and dignity was respected by staff.

People were supported to maintain relationships with their loved ones.

Staff and the management team were knowledgeable of people's preferences.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who enjoyed spending time with them and getting to know them.

People's care plans included their personal history, and preferences for care delivery.

People confirmed they knew how to raise concerns and complaints and felt assured they would be responded to.

People's feedback on their care experience was reviewed to drive improvements.

People had not had the opportunity to discuss their preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems identified the improvements required to the cleanliness of the kitchen, though these were not resolved promptly by the management team.

There was not adequate storage space for equipment for the people living at the home temporarily.

An acting manager was in post and had identified and implemented improvements. We could not be assured these could be sustained or were embedded in practice.

Southfields House

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 was planned to check whether the provider 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.

This unannounced, comprehensive inspection took place on 12 November 2018. We made telephone calls to relatives of people using the service on 13 November 2018.

The inspection team consisted of one inspector, an inspection manager, a medicines inspector 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. In this instance their main area of expertise was in people living with dementia, older people, long-term health conditions, mental health and sensory impairment.

Before the inspection, we asked 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 planned to make. We considered the information provided within the PIR in making our inspection judgements.

We reviewed other information we held about the service. This included notifications regarding important events which the provider must tell us about. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales.

We contacted commissioners of the service and asked them for their views of the service. Commissioners are people who work to find appropriate care and support services for people. We also contacted Healthwatch Northamptonshire, an independent consumer champion for people who use health and social care services, to obtain their views about the care provided at the service.

As part of this inspection, we spent time with people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people that could not talk with us.

During this inspection we spoke with seven people who used the service and the relatives of five people. Some of the people we spoke with had limited communication abilities. We also spoke with nine members of staff including the acting manager, the service manager, two senior team leaders, one team leader, one care supervisor, one rehabilitation supervisor and two carers.

We reviewed four people's care records to ensure they were reflective of their care needs. We also reviewed seven care plans and 15 Medication Administration Records (MAR) to ensure that medicines were being correctly managed.

We reviewed three staff recruitment files, and other documents relating to the management of the service such as maintenance records, audits, feedback from people using the service and their relatives, and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At this inspection we found that there were areas that required improvement.

People were at risk of eating food that was not always safely stored. For example, opened food such as sandwich meat, and condiments in one fridge had not been labelled with the date they were opened and the use by date. Another fridge contained cooked food that was unlabelled including two containers of cooked food growing mould, and one container of cooked rice placed on top of a packet of raw meat. We also observed that vegetables were stored under the sink where the washing up was undertaken and was at risk of being contaminated with dirty water. We brought our concerns to the attention of the team leader, acting manager and service manager who arranged to have all unlabelled food removed.

People were not always protected from the risk of infection due to the poor cleanliness of the kitchen area. Use of agency chefs and care staff in the kitchen had contributed to inconsistencies in the completion of records relating to food hygiene. We found that cleaning schedules for the kitchen had not been consistently completed and observed that the oven hob had not been cleaned and the floor was dirty after the kitchen staff had left for the day. We found the kitchen flooring was ripped and had been taped to prevent any trips or falls. This was a potential breeding ground for bacteria. Following our inspection, the provider promptly arranged to have the kitchen flooring replaced.

People were at risk of being served food that had not been cooked or stored at a safe temperature. Records showed that food temperatures and fridge and freezer temperatures had not been consistently recorded daily.

There was a risk that people's food may not be stored correctly or cooked to a safe temperature. The cleanliness of the kitchen was not in line with current legislation and guidance. This is a breach of Regulation 12 (2) (h) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The food standards agency had visited the home on the 17 September 2018 and had awarded a food hygiene rating of 4, which is good. We made the environmental health officer aware of our findings from the inspection.

Risks to people's safety were assessed and reviewed regularly. Risk assessment records confirmed that risks in relation to moving and handling, falls, skin deterioration and fire evacuation were being appropriately managed. However, we found that risk assessments relating to specific medical needs such as diabetes and epilepsy did not always contain enough information to enable the staff to identify a deterioration in people's health conditions. For example, one risk assessment for a person with diabetes did not identify the signs and symptoms of their blood sugar levels being high or low. Staff we spoke to were not always aware what this would look like in people. People were therefore at risk of not receiving the right medical support at the right time.

Rotas confirmed staffing was consistent and appropriate for people's needs. The provider ensured there were sufficient numbers of suitable staff to support people to stay safe and meet their needs. We received feedback from people living at the home temporarily that staffing numbers were variable. One person told us, "Staff are caring but they are understaffed at the moment. There aren't many of them around in the evening or weekends." People living at the home permanently told us there were always staff available. One person told us "There's always somebody around when I need them." A relative told us, "They [the provider] try and keep the same staff in one unit for consistency. They always have enough staff." A staff member told us, "We have enough staff, if it's a good team everything runs perfectly. Sometimes it's busier depending on the team."

Care staff understood their responsibilities in relation to infection control and hygiene and told us that personal protective equipment (PPE), such as disposable gloves and aprons were readily available for their use. One relative told us, "The staff turn [name of relative] every two hours, they always put on an apron, gloves and discard them in the bin." One staff member told us, "Gloves and aprons are available in the sluice, bedrooms and bathrooms, we have alcohol gel around the home." We saw PPE being used by staff during our inspection. We found the communal areas and bedrooms were clean and fit for purpose.

People were supported by staff that had been recruited following safe recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

People were supported by staff that had a good understanding of safeguarding procedures and could describe what to do if they suspected or witnessed any form of abuse. Records showed staff had up to date training in safeguarding procedures. The management team knew how to escalate safeguarding concerns and had policies and processes in place to ensure prompt action would be taken to keep people safe. One person told us, "I'm safe. That's why I stay here." Another person told us, "I trust the staff completely and I like the way they work." One member of staff told us, "If I had a safeguarding concern I would tell the shift lead and if they did not deal with it, go to [acting manager]."

Some people at the home were prescribed medicines on a when required basis. We found there was no guidance in place to advise staff when and how to give these medicines. Staff told us what these medicines were and when they would give them to individual people. However, the lack of documentation meant that not all staff would be able to give these medicines to people consistently. Some people were prescribed creams and ointments to be applied to their body. These were securely stored in people's own rooms and recorded when applied by staff on separate charts. However, directions from the GP did not specify where to apply. Staff we spoke to were able to tell us where they applied them, however there was inconsistency due to the lack of documentation.

People received their medicine's as prescribed and on time. Staff had received training and were knowledgeable about how to safely administer medicines to people. The provider used Medication Administration Records (MAR) to record when people received their medicines.

People were supported by staff that knew how to report and record accidents, incidents and medicines errors. There was a process in place to investigate incidents. However, we found there was no evidence of learning documented following errors to prevent similar errors re-occurring. For example, we saw evidence of two similar medicines errors. There had been no learning outcome documented after the first error to prevent the second error happening. Further development of the accident and incident reporting was

required to ensure that improvements were promptly identified and addressed.

Requires Improvement

Is the service effective?

Our findings

At this inspection we found that there were areas that required improvement.

People could not be assured they would always receive a balanced diet to stay healthy. A four-week rolling menu had been developed in collaboration with a nutritionist, however this had not been implemented due to inconsistencies within the kitchen staff. At the time of the inspection the provider was using a combination of agency chefs and in-house carers to prepare meals. Meals were cooked according to the kitchen staff members competencies and the ingredients available. We observed during the inspection that people and staff did not know what the meal was until it was served as there was no menu. Staff did not know the potato wedges served with lunch were spicy until they were tasted.

People were at risk of becoming dehydrated. People's care plans recorded how much they usually drank each day, but did not identify what staff should do if they did not drink enough. We observed staff to regularly offer people drinks. However, records showed that while staff recorded how much people drank, they did not record when people had refused drinks to demonstrate drinks had been offered. People's fluid intake was not totalled at the end of each day to identify whether to identify if staff needed to encourage people to drink more if they have not drank enough to keep them hydrated.

Information was available in the kitchen for the chef to be aware of the number of soft and pureed meals required for people with swallowing difficulties, this did not detail who the people were or their food preferences. We observed during our inspection that all people needing a soft or pureed diet were served chicken curry and rice for lunch, they were not offered a choice of meal. Staff told us, and we saw that pureed meals were not always hot once they reached the dining areas and needed to be re-heated.

People living at Southfields house permanently, did not have any cultural dietary requirements. We asked the provider how they would meet the individual nutritional needs of new people living at the home temporarily. The provider told us, each person's needs would be assessed prior to their admission which would enable the provider to liaise with the kitchen staff to ensure meals were prepared to meet people's needs. We found that systems and processes needed further development to ensure the kitchen staff could adapt meals to meet people's differing dietary needs, likes and dislikes.

People and staff told us that the quality of the food was variable. One staff member told us, "The variety of food is not good and the food does not always look appetising. People have a lot of sausages, mashed potato and baked beans." We found inconsistencies in kitchen staffing impacted on the variety and quality of meals available to people. Relatives of people living at the home told us. "I visit mostly at tea time, I haven't seen any food that wasn't presented well." Another relative told us, "They [provider] have arranged high calorie drinks and yoghurts for [relative] and if [relative] doesn't eat well, they make a hot chocolate. They [care staff] encourage [relative] to eat regularly."

We observed mealtimes to be a relaxed and sociable occasion. People were offered a choice of burgers in rolls with wedges, or chicken curry with rice and a choice of drink. Staff sat with people while they ate their

meals and talked to them about their interests. We found that on the day of inspection, many people were not keen on the lunchtime choices available. However, if people did not like their meal they were offered an alternative. We observed staff to know people's food and drink preferences and ensure that people had eaten as much as they were able. For example, one person did not like the burger and did not wish to eat curry. A staff member offered to cook them soup which they accepted. The staff member then recalled the person enjoyed cheese and salad rolls, and offered this as an alternative. The person smiled when they were offered the roll and accepted this choice. As each unit had its own kitchen area, staff could prepare simple meals for people at their request. One staff member told us, "We can cook people things in the kitchen, yesterday a lady wanted poached eggs on toast for breakfast so we cooked it for her."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The provider had appropriately submitted Deprivation of Liberty Safeguards (DoLS) applications to the local authority.

We found that the provider was not always was working within the principles of the MCA. Where MCA assessments had been completed, best interest assessments for care and treatment had not always been undertaken and the provider did not always check and record whether people had a lasting power of attorney (LPA). This is an ongoing arrangement that will allow another person to make decisions on people's behalf. Some people at the home were given their medicines disguised in food or drink without their knowledge (covert administration). We found this was consistently carried out in their best interest following assessment under the MCA and a documented best interest review, which included an advocate for the person, pharmacist and GP.

Staff understood their responsibility around the MCA and had received training. People told us and we saw that staff always asked for consent before supporting with care and respected people's decisions. One relative told us, "My [relative] has no capacity, the staff are so patient and so lovely, I can't tell you how glad I am." The acting manager had identified the need to review mental capacity assessments and consider whether best interest decisions were required and had an action plan in place to complete these.

The provider had systems in place to assess and identify the support people required before receiving care. The management team completed risk assessments and care plans with people and their relatives where appropriate. These were updated as they got to know people or as their needs changed.

People received care from staff who had the skills and knowledge to meet their needs. Records showed staff had an induction and had undertaken training for their role, which the provider deemed mandatory. This included training in medicines, safeguarding of vulnerable adults, moving and handling, infection control, nutrition and hydration, MCA and health and safety. One staff member told us, "The training is brilliant I cannot fault it." Staff working in the reablement part of the home told us they had been provided additional training to meet the needs of people living at the home temporarily. One staff member told us, "I have care plan training this week and have just done my medicines training. I will be doing the moving and handling

assessor training so I can work with the occupational therapists when people come for reablement to help identify the right equipment for when they go home."

Staff felt supported by the acting manager and confirmed they received regular supervisions and appraisals. One staff member told us, "I have regular supervisions [name of acting manager] is very supportive." Another staff member told us, "I get positive feedback."

People were supported to live healthier lives and maintain good health by attending regular health checks and medical appointments. The provider had systems and processes in place for referring to external health care services and records showed the provider had liaised with health professionals to ensure people's care plans remained up to date. One relative told us, "I rang up about [relatives] eyesight, they [provider] sorted an optician appointment straight away."

People living at Southfields House were registered with six differing GP practices, which created some operational challenges in ensuring everyone's health needs were met in a timely manner. Staff told us that they had requested GPs to carry out annual medicines reviews for people at the home, however they had not been completed. We saw people with diabetes had their blood glucose levels checked at regular intervals by the district nurses. The provider told us, they would be offering people the choice to transfer to one GP practice with the view that this would enhance the working relationship with the GP surgery and improve the response time for medical advice and intervention.

People receiving reablement support had access to an advanced nurse practitioner (ANP) three days a week and a physiotherapist and occupational therapist. The provider had built a staircase and was developing a gym to ensure that people's needs could be appropriately assessed to assist people to return to their own homes sooner. During the inspection we observed care staff to support an occupational therapist to encourage a person to use a standing hoist.

People living at the home permanently were encouraged to personalise their bedrooms to their choosing. One relative told us, "[Relative] has a budgie from home in [their] bedroom, it has made such a difference." There was an accessible garden space for people to use in good weather and communal areas available for people and their visitors to use. One relative told us, "In the summer when the weather is nice the staff encourage people to sit outside." A staff member told us, "In the summer we use the garden, this summer we made a beach in the garden, people sat outside with ice creams."

Good

Is the service caring?

Our findings

People and their relatives were happy with the care and support they received. Throughout our inspection we observed staff treating people with warmth, kindness and compassion. Staff interacted with people in a polite and respectful manner and frequently shared a laugh or joke with people. We found Southfields House to have a relaxed and happy atmosphere.

Staff and the management team all spoke positively about the people using the service, and were knowledgeable about people's needs and preferences. The care plans advised how people wanted their support provided. This helped staff to provide person centred care that fully supported and respected people's individuality. One relative told us, "My [relative] shouts a lot, the staff take it on the chin and speak sweetly to [relative]." Another relative told us, "I go in regularly and the care I see for my [relative] and other people is good. The staff are friendly and their attention to people is brilliant."

The staff were committed to supporting people to enhance their lives and maintain their independence. We observed one person become distressed due to confusion regarding their drinks. A staff member patiently explained to the person what was in each cup and encouraged them to touch the cup to feel the temperature and identify the cup of tea. The person was visibly reassured by the explanation.

The management team and staff understood when people may need additional support from an advocate. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive and when they are unable to speak up for themselves the advocate will represent them to ensure any decisions are made in their best interests. At the time of the inspection nobody required the use of an advocate as all people were supported by their family members.

People were supported by staff that respected their privacy. Information about people was shared on a need to know basis. We saw people's care files were kept within a locked cupboard. The management team were aware of their responsibility in complying with the Data Protection Act and the General Data Protection Regulation. Use of a complaints and compliments book for people visiting the service had been reviewed and temporarily removed as visitors had recorded personal identifiable information within, which was not compliant with legislation.

We saw that care was carried out in a dignified and person-centred way. One person told us, "When staff come into my room they will shut the door before they take the throws off. If I am lying in bed they will cover me with a towel." A relative told us, "They [staff] shut the curtains when doing personal care even though the room is not overlooked."

People were supported to maintain relationships with their loved ones, relatives we spoke told us they could visit or call any time and join their relatives for meals. One relative told us, "I can phone in the middle of the night and ask the staff to look in on [name of relative] and they will." We observed visitors coming and going throughout our inspection.

Good

Is the service responsive?

Our findings

There was a person-centred approach to the service offered. Each person had a care plan tailored to meet their individual needs and had been recently reviewed. People, and where appropriate, their relatives were involved in developing and reviewing their care plans. The care supervisor told us, "I am focussing on speaking to carers, families and people to get the care plans right, they needed reviewing and personalising." We saw daily records were maintained to demonstrate the care provided to people and that people received their care as planned.

Staff told us that the care plans gave them enough information to be able to support people effectively. One staff member told us, "We have to read all of the care plans and are told when they change." A communication book ensured staff were made aware of any changes to people's care needs. For example, we saw a message that prompted staff to read an updated nutrition care plan for one person.

People's care plans demonstrated the management team had taken time to get to know them and involved them in completing risk assessments and planning their care. The care plans were adapted to meet people's individual needs and how they wished to be supported. For example, one person's care plan recorded that when they woke staff needed to remind them of their name and ask if they wished to get up. Another person's care plan detailed the order they wished to receive their personal care as this was important to them.

People were supported by staff who enjoyed spending time with them and getting to know them. People's personal history was recorded in their care plans and staff demonstrated an awareness of people's history. One relative told us "Staff paint [relatives] nails, do their hair and make sure they are wearing matching clothes. This has always been really important to my [relative]." We observed a staff member affectionately telling this person, "You look beautiful, like Marilyn Monroe." The person responded with a smile. We observed laughter and positive interaction between staff and people during our inspection.

People did not always have access to meaningful activities. A member of staff told us, "There are not enough activities, most people watch TV." The acting manager had identified that activities for people living at the home were limited and had arranged for two dementia day centre officers to visit Southfields House and suggest activities for staff to undertake with people. The shift leader had taken on the role of co-ordinating these activities. A member of staff told us, "The shift leader works really hard to co-ordinate activities. Previously people have not been out much, but we are planning days out like shopping and lunch out." The provider had arranged for a pony to visit the home for Halloween, photographs on display at the home showed people's positive reactions.

Throughout our inspection we observed staff engaging some people in activities. For example, reading a book and doing puzzles. However, this was dependent on the availability of staff in each unit. There were times when people were unsupported. One relative told us, "Staff spend time with [relative] showing photos of family and reading books, they get on well with [relative] and find [relative] uplifting." Another relative told us, "They [provider] don't exclude my [relative] from anything... When they brought some farm animals in the

staff took them out so that [relative] could stroke them."

Peoples social and cultural diversities, values and beliefs were considered during the initial assessment and staff demonstrated an understanding of equality and diversity. The provider had ensured people's individual needs had been considered and responded to. For example, one person was visited by a faith leader each week. The acting manager told us they were exploring the possibility of partnering with a local nursery to provide intergenerational support as they felt people living at the home would really benefit from spending time with pre-school children.

The provider understood it needed to look at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider told us, that they had access to an interpreter and would translate information into people's first language where required.

The acting manager at Southfields House had identified that surveys did not capture the information needed for the home to identify improvements needed. Thoughts and feelings boards had been introduced in each unit for people, staff and their visitors to record their feedback. These were reviewed monthly and an action plan put in place to address the improvements. We saw that people's feedback had been responded to. For example, a Christmas pantomime had been booked and painting activities purchased.

People confirmed they knew how to raise concerns and complaints and felt assured they would be responded to. We saw that complaints information was available to people upon entering the home. There had not been any formal complaints made within the last year. One person told us, "I have never had to complain, but if I had to I would talk to the shift manager and if I was still not satisfied, I would write a letter." Another person told us, "If I've had a concern it gets dealt with straight away." A relative told us, "Staff sort the little things very quickly, but they always provide me with feedback which is very important e.g. if [relative] had a small fall which resulted in a bruise, or if they had to call the paramedics in, they tell me everything…what happened, what action was taken and what the situation is. They engage with me all the time." Audit records showed the acting manager had met with three relatives, to discuss their concerns regarding meals.

People had not had the opportunity to discuss with staff what it meant to be at the end of their life and make their preferences known in an advanced care plan, such as remaining in the home or receiving care in a hospital. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care. However, we found the acting manager had identified the need to implement end of life care plans for people living at Southfields House prior to the inspection and had an action plan in place. As part of this a member of staff had been supported to undertake the Gold Standards Framework training in end of life care and training sessions had been planned for the whole staff team for the month of the inspection. The acting manager told us that following the training all end of life care plans were to be completed with people living at the home and their relatives where appropriate. A member of staff told us, "Some people have a funeral plan in place but the care plans need to be more robust and person centred."

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found that there were areas that required improvement.

The provider had notified us that the registered manager was absent from work. 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. The provider had appointed an acting manager as an interim arrangement. The acting manager understood and carried out their role of reporting incidents to CQC, we found that all legally required notifications had been submitted.

Quality monitoring systems were in place. These included a series of audits carried out by the acting manager and team manager. For example, people's care plans, food and drink, weights and health and safety. Quality monitoring systems and processes identified areas that required improvement but were not always effective. For example, records showed that concerns with the cleanliness of the kitchen and food labelling had been identified in September 2018 during a kitchen meeting and through audits. However, we found this had not been satisfactorily addressed due to the inconsistencies in the kitchen staffing and lack of oversight of the kitchen.

We found the acting manager had identified many areas of improvement through audits, and had an improvement plan in place to address these. The acting manager acknowledged that the main area that required improvement was nutrition and hydration and had worked alongside a nutritionist to develop a menu. However, it had not been possible to implement the new menu due to the home not having sufficient and consistent staffing in the kitchen. The acting manager told us, the menu would be reviewed once they had received feedback from the thoughts and feelings boards to ensure the menu reflected people's preferences and nutritional requirements and would be implemented with the recruitment of a permanent chef.

Although accidents and incidents were reviewed as part of the monthly management audits to identify any improvements, we found there was no review immediately following an incident to identify any actions that would minimise the risk of re occurrence. Further development of the accident and incident reporting was required to ensure that improvements were promptly identified and addressed.

The reablement part of the service was in its infancy. The provider was in the process of developing relationships with health and social care professionals to enhance the discharge process and ensure people received the right support while staying at Southfields House for them to be able to return home as quickly as possible. The provider had identified there was not enough storage space for the equipment required to meet people's needs and was in the process of securing additional storage. In the interim, we found there was not adequate storage for pressure relieving mattresses that were not in use and found 4 pressure relieving mattresses were being stored in the shower room. This prevented people from being able to have a shower when they needed it.

Some people at the home were prescribed medicines on a when required basis. We found there was no guidance in place to advise staff when and how to give these medicines. Staff told us what these medicines were and when they would give them to individual people. However, the lack of documentation meant that not all staff would be able to give these medicines to people consistently. Some people were prescribed creams and ointments to be applied to their body. These were securely stored in people's own rooms and recorded when applied by staff on separate charts. However, directions from the GP did not specify where to apply. Staff we spoke to were able to tell us where they applied them, however there was inconsistency due to the lack of documentation.

Medicines including controlled drugs (CD) were appropriately stored in accordance with legal requirements. However, regular audits of the CD balance were not being recorded to ensure records matched physical balance. We made a recommendation for the provider to review its policy to ensure CD stock balance is checked and recorded regularly.

It is a legal requirement that a provider's latest CQC inspection report and rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about the service can be informed of our judgments. This is the providers first comprehensive inspection. The provider was aware of the legal requirement to display the registration certificate and rating from this inspection.

The acting manager had been in post for a short time. We found the acting manager to be passionate about promoting a positive culture that is person-centred, open, inclusive and empowering, whilst achieving good outcomes for people. Records showed that poor practice was challenged. People, their relatives and staff all felt confident that they could raise any concerns with the acting manager and these would be dealt with promptly.

The acting manager had identified many areas that required improvement within the home and had an action plan in place to address these. For example, care plans had been reviewed and re-written to ensure they were person centred; additional training had been co-ordinated to ensure staff had the appropriate skills and competencies to undertake their role within the reablement service and end of life care training had been co-ordinated for the whole staff team. Audit records showed the acting manager was actioning areas of improvement identified during the monthly audits. For example, the acting manager had identified staff required dementia awareness training. At the time of the inspection, most of the staff team had undertaken the training. One staff member told us, "The most interesting training I have had was the dementia training." The acting manager had made improvements to peoples lived experience of dementia. For example, colour coded cutlery and contrasting tablecloths had been introduced to assist people with eating at mealtimes and activities had been purchased to enhance people's skills and experiences.

The management team were open and honest with us throughout our inspection. They were receptive to any shortfalls highlighted, and set about to action those within their control on the day of the inspection. For example, the provider promptly arranged to have the kitchen floor replaced and the acting manager ensured fluid totals were added to fluid monitoring charts. Whilst we observed the acting manager had made improvements to people's care experience, we could not be assured that the improvements made would be sustained and were embedded in practice.

Staff meetings occurred monthly, records showed that staff meetings were used to discuss any issues relating to practice to drive improvement. For example, ensuring full completion of nutrition charts, cleanliness of the home and confidentiality.

The management team encouraged and valued feedback from people and their relatives. The acting

manager had reviewed the effectiveness of surveys for people that lived at Southfields House and found the feedback was not meaningful to shaping the service offered. A thoughts and feelings board had been introduced in each unit for people, relatives and staff to record people's wishes regularly throughout the month, these were then reviewed and an action plan devised. We saw these in use, with people making suggestions such as requesting fish and chips from the chip shop and visiting a pantomime. A pantomime had been booked and fish and chips planned.

People, relatives and staff knew the acting manager by name. We saw people had formed a good relationship with the acting manager within a short space of time and received positive feedback from relatives and staff. One staff member told us, "[Name of acting manager] has made a lot of good changes and is getting on top of things." People felt confident in raising concerns with the acting manager. One staff member told us, "I raised a concern with the acting manager about a member of staff, it was dealt with. I've worked with the staff since and there have been no issues." Relatives gave us positive feedback about the home. One relative told us, "If I had to start again to find a place, I would pick this one."

The provider worked in partnership with other agencies. Records showed, and we saw the provider worked with health and social care professionals involved in people's care to ensure their care plans were current and people's health and wellbeing needs were being met. For people using the reablement service the staff team were in close contact with the hospital, advanced nurse practitioner, GP surgery, occupational therapist and physiotherapist.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a risk that people's food may not be stored correctly or cooked to a safe temperature putting people at risk of becoming unwell. This is a breach of Regulation 12 (2) (h) Premises and Equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014