Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
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Bradford
West Yorkshire
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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 personal care to 39 people, most of whom were aged 65 and over at the time of the inspection. The service can support up to 54 people. Southfield Care Home accommodates people in one adapted building.

People's experience of using this service and what we found

People were not always safe. Government guidance on the prevention and control of infection was not always followed which meant people were at risk of catching an infection. None of the people using the service had COVID-19 when we visited. The provider was supporting people and staff to have regular COVID-19 tests. Relatives of people using the service told us they had been supported to keep in touch during the pandemic.

Overall people were receiving their medicines as prescribed. However, we found the systems for the overall safe management of medicines were not robust enough.

We found risks to people's health and safety were not always managed properly, this included risks to people's nutrition and skin integrity.

Recruitment checks were not thorough and did not ensure staff were safe and suitable to work in the service. There were not always enough staff to meet people's needs and keep them safe. Staff had not been provided with all the training they needed to carry out their duties and were not always supported in their roles.

There was a lack of effective and consistent management of the service. The registered manager left in January 2020 and since then there had been three managers, none of whom had registered with CQC.

The provider's systems for assessing and monitoring the safety and quality of the services provided were not effective in identifying shortfalls and improving the service.

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

Rating at last inspection
The last rating for this service was good, (published 12 February 2019).

Why we inspected
This inspection was prompted in part due to concerns received about management and staffing. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous

comprehensive inspection for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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.

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 coronavirus and other infection outbreaks effectively.

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 infection prevention and control, medicines, staffing, 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 is therefore 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 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 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 and an Expert by Experience who conducted telephone interviews with people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Southfield 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 is run and for the quality and safety of the care provided. The manager who was present at the time of inspection had been in post for approximately seven weeks.
Notice of inspection
This inspection was unannounced.

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. We contacted Healthwatch which is an

independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 19 relatives by telephone about their experience of the care provided. We spoke with two care workers, the deputy manager, the manager and two company directors. We looked around the building and observed people being supported in the communal rooms.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- Government guidance on the prevention and control of infection was not always followed.
- Some of the senior management team were wearing fabric masks. Where staff were wearing the required fluid resistant masks, they were not always wearing them properly. This posed a risk staff could transfer infection.
- Social distancing guidance was not consistently followed. Armchairs were placed side by side in the communal areas which meant people were seated close together. The manager told us the policy was to have no more than two people at each table at mealtimes. This was not adhered to, for example, at lunchtime we saw a staff member supporting a person to sit at a table where two people were already seated.
- Government guidance on promoting good ventilation was not always followed. For example, at lunchtime all the windows were closed in the lounge/dining room.
- There was no evidence action had been taken to consider and reduce the impact to people and staff who may be disproportionately at risk of COVID-19. The manager told us individual risk assessments linked to the Covid-19 virus had not been carried out.
- Records showed some staff had not received any infection prevention and control training and others had not received this training for over a year.
- Infection prevention and control audits were not consistently carried out and when they were there was no evidence action had been taken to address shortfalls.

At the time of our inspection none of the people using the service were confirmed or suspected of having contracted COVID-19. However, systems were not robust enough to demonstrate infection prevention control was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured the provider was accessing COVID-19 testing for people using the service and staff.
- The home was restricting visitors in line with current government guidance. There was a clear process in place for essential visitors including completing track and trace information and recording temperature checks.
- Most of the relatives we spoke with told us they had been supported to keep in touch with people during the pandemic. Comments included, "[I] have talked with[my] relative on the phone, some of the staff let us do FaceTime using their phones. They are brilliant at that" and "Saw my relative through the front door on their birthday, left cards and gifts but they had to go into isolation for 72 hours."

Using medicines safely

● Medicines were not always managed safely.

● Medicines were not always stored in line with good practice guidance or the provider's own medication policy. No temperature checks had been recorded for the medicine's storage room or the area where the medicine trolleys were stored. Medicine trolleys were not anchored to the wall in line with the providers policy.

● Emollient creams were stored on a shelf in people's rooms. This was not secure and placed people at risk of harm, particularly people living with dementia. Risk assessments had not been carried out about the risks of storing creams in people's rooms. The deputy manager told us they were aware risk assessments needed to be done.

● There was no evidence staff involved in the administration of medicines had received training while working at Southfield Care Home. There was no evidence medication competency assessments to check staff were administering medicines safely had been carried out.

● There were no photographs of people held with the medication administration records for identification purposes and information about allergies was not recorded. The deputy manager told us they were following this up. However, records showed this had been identified on 6 November 2020 and no action had been taken to address it at the time of our inspection.

● Protocols were not in place for all medicines prescribed to be taken 'as required' (PRN). Those that were in place were very brief and did not provide any person-centred information.

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

Following our inspection the provider confirmed they were taking action to address the concerns identified.

● People's medication files were well organised, and the medication administration records were clear and generally well completed.

● The deputy manager told us they were working closely with external health care professionals to ensure people got the right medicines to help them with any anxiety but to avoid over sedation.

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

● Risks to people's health and safety were not always managed properly.

● In the case of one person we found it had taken over three weeks for the service to act in response to concerns about weight loss. Even after action had been taken the person's care plan was not detailed enough to show staff what they needed to do to support the person to improve their dietary intake.

● Another person was receiving treatment from the district nurses for a pressure sore which they had sustained before moving into Southfield Care Home. There was no care plan in place to guide staff on how to support the person and follow the treatment plan set out by the district nurses.

● Accidents and incidents were recorded. However, there was no evidence this information was reviewed or used to reduce the risk of similar incidents happening again.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate risks to people's health and safety were properly assessed, monitored and managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● External health care professionals confirmed staff were following the treatment plans they had put in place.

Staffing

●There were not always enough suitably trained and qualified staff to meet people's needs in a timely way.

● On most days the home had six care workers on duty in the morning, this reduced to five in the afternoon. The home did not have an activities organiser. Care workers were responsible for supporting people to engage in social activities and spend their time meaningfully. In addition, there were no housekeeping staff in the afternoon. This meant care staff had the additional task of completing hourly high touch point cleaning.

● Staff expressed concerns about staffing levels particularly in the afternoon. They said they now have less staff and more people who need support. This supported information we had received about the service which showed that in September 2020 the service was operating with six care workers during the morning and afternoon when occupancy was lower. In addition, we found an early morning shift which had been put in place in September 2020 was no longer in place.

● We observed staff had very little time to interact with people in a meaningful way. Interactions were focused on tasks and there was little or no meaningful activity taking place during the day.

● The provider was unable to demonstrate staff had received the training and support they needed to carry out their roles. There were five members of staff listed on the training matrix with start dates between January 2018 and October 2020 for whom no training was recorded.

● The training matrix showed only three members of staff had been supported to undertake formal training leading to a nationally recognised qualification in care.

●The service supports people living with dementia. However, the training matrix showed only four staff had received training on dementia and in all cases their training was overdue for renewal. Some of the language used by staff, for example, "She's a two" when talking about someone who needed two staff to support them suggested a lack of understanding of a person centred approach to care.

The provider was unable to demonstrate there were enough suitably qualified, competent and experienced staff deployed at all times 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.

Recruitment

● Staff were not recruited safely as thorough checks had not always been completed before employment commenced.

● In two staff files there was no evidence the provider had carried out checks with the Disclosure and Barring Service (DBS) before staff started work. DBS checks help employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

● Neither of the two files had any evidence of a recruitment selection process or interview. In one of these files there was no application form or information about the staff member's employment history. There was only one reference and that was from a co-worker, not the person's previous employer.

The lack of a robust recruitment process meant people were not 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.

Systems and processes to safeguard people from the risk of abuse

● Relatives told us they felt the service was safe and said they were kept informed about any accidents or changes in people's needs.

● Staff confirmed they had received safeguarding training and they demonstrated an understanding of abuse. They said they were confident about reporting any concerns and told us they felt people living at Southfield Care Home were safe.
● The manager understood their safeguarding responsibilities and had reported concerns to the local authority safeguarding team as and when necessary.

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 good. At this inspection this key question has now deteriorated to 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There had been a lack of consistent and effective management at the service since January 2020. The last registered manager left in January 2020. Since then the service has had three different managers, none of whom have applied for registration with CQC. Comments from relatives included, "Management never make themselves known to you" and "Management has changed a lot recently, don't really know who to speak to now."
● Staff said morale had been low due to the constant changes of manager. Comments included, "It's a bit haywire" and "We don't know if we are coming or going."
● There was a lack of effective provider oversight and monitoring. This meant the provider had not been able to sustain the improvements they had made at the last inspection which created a risk to the health, safety and wellbeing of people using the service. For example, audits were not consistently carried out and the audits that had been done had not been effective in bringing about improvements. For example, the most recent infection prevention and control audit which had been carried out in September 2020 referred to an action plan, but the manager was unable to find any action plan. The staff recruitment files we looked at had significant shortfalls linked to safe recruitment processes.
● Risks to people's health and safety were not effectively managed. For example, the gates to an enclosed outside space directly outside a fire exit had been fitted with pad locks despite the fact the fire authority had informed the provider this type of lock was unsuitable. While this was rectified quickly following our visit it had not been picked up by the provider's quality and safety monitoring systems.
● People's care records were not always up to date and were not person centred. Staff spoke fondly about people and seemed to know them well. However, some of the language used by the staff team suggested an institutional approach to care. Comments heard included, "She's a two (meaning two staff were needed to support the person)", "We used to do all the soft first (meaning supporting people who required soft diets first)" and "I'll feed him in his room."
● The provider did not promote a culture of continuous learning and improvement. Training records showed staff had not received the training they needed to carry out their roles and they were not supported to develop their knowledge and skills. Staff told us they had not received any one to one supervision for at

least three months.
● The provider was unable to demonstrate how they had supported people who used the service and their relatives to share their views and contribute to the improvement of the service.

We found no evidence that people had been harmed however, systems to assess, monitor and improve the safety and quality of the service were not sufficiently robust. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff said the new manager was approachable. They said they had regular staff meetings.

Working in partnership with others
● The new manager was working to develop positive working relationships with external agencies. For example, they had started having regular meetings with the district nursing team to improve communication and partnership working. They had also arranged for a nurse practitioner to visit the home every week to review people's medical needs.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not robust enough to ensure robust recruitment checks were completed before new staff commenced employment. The required information was not available in respect of each person employed. 19 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. 18 (1) Staff were not provided with appropriate training and support to carry out their duties. 18 (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not robust enough to demonstrate infection prevention and control were well managed. Reg 12 (1) (2) (h) Systems were not robust enough to demonstrate the safe and proper management of medicines. Reg. 12 (1) (2) (g) Systems were not robust enough to demonstrate risks to the health and safety of service users were assessed and effectively managed. Reg. 12 (1) (2) (a) (b)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the safety and quality of the service were not effectively operated. 17 (1) (2) (a) Systems to assess, monitor and mitigate risks to the health, safety and welfare of service users and others were not effectively operated. 17 (1) (2) (b) Accurate and up to date records were not maintained in respect of each service user. 17 (1) (2) (c) Accurate and up to date records were not maintained in respect of staff employed and the management of the regulated activity. 17 (1) (2) (d) (i) (ii) Effective systems were not operated to seek and act on feedback from relevant persons and to use this information to bring about improvements. 17 (1) (2) (e) (f)

The enforcement action we took:

Warning notice