Southfield Health Care Limited

Southfield Care Home

Inspection report

Belton Close
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Bradford
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Southfield Care Home is a residential care home providing accommodation and personal care for up to 54 people aged 65 and over. At the time of the inspection there were 33 people living at the home. Southfield Care Home accommodates people in one adapted building over two floors.

People's experience of using this service and what we found
People continued to be at risk of harm as the provider had not assessed and mitigated the risks to people. This included hazards in the environment of the home as well as risks associated with people's health and care needs. Medicines were not managed safely.

There were not enough staff to keep people safe. We observed staff were caring but they were rushed, and routines were task orientated. People were regularly left on their own for long periods of time and there were limited opportunities for meaningful social interactions. Staff were not always able to respond quickly where people needed care, support or comfort. People were not always protected from abuse or neglect.

People had not been protected from the spread of infection because systems and processes were not in place.

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

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

Systems to assess, monitor and improve the service were not effective. Shortfalls identified at the last inspection had not been addressed. The provider did not demonstrate they understood their legal responsibilities. Governance systems were ineffective, and the provider did not have oversight of key safety issues.

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 29 January 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had 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. We met with the provider after the second day of the inspection. We discussed our concerns about the staffing levels and shortfalls in infection prevention and control practises. The provider sent us an action plan and assured us they would increase staffing levels immediately and take action to mitigate infection control risks.

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, infection prevention and control, assessing and managing risk to people, 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 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 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. The second day of the inspection was carried out by three 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 no manager employed at the time of the inspection.

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 one person who used the service and seven relatives about their experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with eight members of staff including the nominated individual, deputy manager, senior care workers, care workers and a cleaner. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with staff and relatives over the telephone.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We held an online meeting with the nominated individual and a representative from the local authority to discuss our urgent concerns. We requested additional evidence and documentation from the provider that was not available on the day of the inspection and we reviewed this.

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. At this inspection this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to demonstrate there were enough suitably qualified, competent and experienced staff always deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

Staffing

- Safe staffing levels were not maintained, and staff were not effectively deployed. On both days of the inspection there were six staff on duty, but rotas showed us this regularly reduced to five staff. We observed people's needs were not being met, altercations between people and people being left on their own for significant periods of time.
- We observed a person nearly falling out of a chair on two occasions. On multiple occasions people asked inspectors for support to go to the bathroom when there were no staff available. There were not enough staff to support people at mealtimes. For example, we observed one person who walked around the dining area repeatedly taking food from other people's meals. Staff were not available to assist people or intervene.
- Staff were rushed and did not have time to have meaningful conversations or participate in activities. Over the course of the inspection we observed people sitting in the same chairs for long periods of time without staff present. Staff were not available to respond promptly when people needed care, support or comfort.
- The provider told us lower staffing levels were as a result of reduced occupancy. There was no evidence of a dependency tool being in place to calculate staffing. At the time of the inspection people were using four communal areas and their own bedrooms. The lift was out of order. We were not assured these factors had been considered in assessing the staffing levels.
- Staff told us they had raised concerns about the staffing levels during the day and night with the provider and no action had been taken. Comments included, "We need more staffing" and "Residents do not get the attention they need. There is not always someone [working] on the floor."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate there were enough staff deployed to care for people safely. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider immediately after the inspection. The provider assured us they would increase staffing levels immediately and complete a robust dependency assessment to identify the appropriate staffing levels to keep people safe.

Recruitment

At our last inspection the provider had failed to demonstrate robust recruitment processes were in place to ensure people were protected from the risks associated with the employment of unsuitable staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Safe recruitment practises were not followed.
● We reviewed two staff recruitment files. In both files there was no evidence gaps in employment history were explored. References had not been sought from staff's most recent employment in a health and social care setting. This meant the required employment checks to ensure staff were suitable to work with people had not been completed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff were recruited safely. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

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

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

● Risks to people's health and safety were not assessed and care plans did not contain detailed information. Care records did not explain how to keep people safe. For example, risks relating to people's mobility, skin integrity, nutrition and mental health were not assessed and monitored. Records indicated multiple examples when people were losing weight or having unwitnessed falls, and this was not reflected in their risk assessments.
● For example, one person had lost 7kg in weight between February and April 2021. The person's nutritional care plan had not been updated to reflect this. This meant the person was at an increased risk of malnutrition.
● Another person had recently been experiencing heightened periods of anxiety. This resulted in their mood and behaviour being unsettled and there were occasions when they had hit out at other people living at the home. Risk assessments did not provide any details about their behavioural or emotional needs or how staff should respond when they were upset. This meant the person was not supported consistently and there was an increased risk of harm to themselves and other people they lived with.
● Routine safety and environmental checks were not consistently in place. Buildings checks were not robust

and maintenance issues were not followed up promptly. There was a leak in one person's bedroom. This had been identified but no follow up action had been taken.
● On the first day of the inspection we saw a broken window in the conservatory area of the home. People were using the area and we saw people sitting just below it. The edges were sharp and covered with a plastic bag. This presented a high risk of injury or serious harm. We discussed this with the provider, and they organised for the window to be safely boarded on the same day. There was no system in place to ensure appropriate checks of the environment were completed, therefore safety issues we found had not been identified.
● Government guidance on the prevention and control of infections was not always followed. Personal protective equipment was not consistently worn by staff. We observed multiple occasions when staff were not wearing face masks properly. This meant risks to vulnerable people were increased and they were at a heightened risk of infection.
● Clinical waste was not stored safely. On both days of the inspection the external clinical waste bin was overflowing, and clinical waste bags were not secured. There were not enough cleaning staff deployed to keep the home clean. Cleaning schedules, including high touch points had not been maintained.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risk 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.

● People and staff at the home were following a regular testing and vaccination programme for COVID-19. Relatives were being supported to visit people in the home in line with government guidance.

Using medicines safely

At our last inspection the systems were not robust enough to demonstrate medicines were managed effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Medicines were not always managed safely.
● Medicines were not stored safely and securely. There were no temperature checks where medicines trollies were kept and not all trollies were secured to the wall.
● At the last inspection we identified staff had not had training to administer medicines. At this inspection we found no action had been taken. Staff had not received training and their competency to administer medicines had not been assessed.
● Protocols were not in place for people who were prescribed 'as required' medication. Where they were in place, they were not accurate, person centred or up to date. One person had recently been prescribed medication to support them with anxiety. There was no guidance in place for staff to say how and when this should be administered. This meant people were at risk of not receiving their medicines when they should.
● At the last inspection we raised concerns prescribed creams were stored on open shelves in people's rooms. This practise had continued and there were no risk assessments in place to assess if this was safe. Administration records had been put in place in April 2020. However, there were gaps where staff had not signed the record and there was no information for staff about how, when or where to apply creams.
● Medicine ordering systems were not effective as some people had not received their medicines as they

had run out. For example, one person had not received their medicines for two days.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were managed safely. 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

● We reviewed the training matrix and staff had not received up to date training. The provider's safeguarding policy stated staff should receive annual training. However, we identified 17 staff had not received any safeguarding training and other staff training was out of date.

● Staffing levels meant there were not enough staff to observe and support people. We observed a safeguarding event between two people. There was a physical altercation and this resulted in both people becoming distressed and hitting each other. There were no staff present to offer support and intervene. We informed the deputy manager about the event but over the course of the day we observed the two people were left together in an area without any staff supervision.

● Records showed potential incidents of abuse and allegations of abuse had occurred but were not routinely referred to the local safeguarding authority. We identified multiple 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 were not assured service users were protected from the risk of injury or harm from abuse

We observed two people hitting each other. We found no other evidence that people had been harmed however, systems were either not in place or robust enough people were protected from abuse and neglect. This placed people at risk of harm. 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.

● Relatives told us they thought people were safe living at the home. One relative said, "Yes, [person] is safe. I have no concerns about how they look after [person]."

● Staff were able to describe different forms of abuse and the ways they would report this.

Learning lessons when things go wrong

● People's care plans were not reviewed after serious events. Systems were not effective in learning lessons when things went wrong.

● Accidents and incidents were recorded but there was no evidence of reviews or management oversight. Forms were incomplete and details of follow up action taken by the manager or the provider not completed. There was no evidence of analysis to identify themes, trends or lessons learned.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

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 were identified at this inspection. Systems should have been in place to ensure the provider was aware of how the service was operating and to ensure compliance with regulations. Effective systems had not been put in place after the last inspection to address the concerns and drive improvement. Where audits were completed, they were not effective at identifying issues. For example, the medicines and infection, prevention and control audits had not identified the issues we identified at the inspection.
● Policies and procedures were in place, but they were not always followed and did not reflect current guidance.
● 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 most recent manager left in March 2021.
● There was no effective system in place to manage or assess the risks to people and improve the quality of care. For example, one person had fallen on two occasions in March 2021. On one occasion they had required admission to hospital. Their risk assessments had not been updated to reflect this. This left people at risk of injury and their health and wellbeing deteriorating.
● Staff provided mixed feedback about how the service operated. They spoke about people in an affectionate and caring way and expressed their concern about how staffing levels impacted on how much time they could spend with people. One staff member said, "We are a team. We work together. We want to be back to good."
● People did not always receive person centred care that led to good outcomes for them. 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 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. There was no manager in place, and the provider did not have oversight of the home. They had not addressed issues raised at the last rated inspection.

● Providers must ensure their rating is displayed conspicuously and legibly at the location. On both days of the inspection we saw the rating from the last inspection was not displayed. We asked the provider to ensure their most recent rating was displayed.

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.

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

● The service had been supported by the local authority and other professionals for a period of time. They were being supported to improve standards using an action plan. However, during the inspection we identified significant progress had not been made.

● There was no activity lead in post and care routines were rushed and task orientated. There were limited opportunities for people to engage in person centred group or individualised activities.

● The provider was unable to demonstrate how they involved people and their relatives to share their views and contribute to developing the service.

● We received mixed feedback from relatives. Most relatives said they were happy with the care provided but we received conflicting comments about communication from the home. One relative said, "When there is a slight change in [person] they tell me." Another relative said, "Sometimes communication is poor. For example, you don't get the right information and you have to wait for it. They [staff] do not seem to communicate with each other."

Continuous learning and improving care

● The provider could not demonstrate continuous learning and improvement. The significant shortfalls identified at the last inspection had not been addressed.

● After the last inspection the provider had commissioned a consultant to support with service improvements. We requested a copy of the action plan, but we did not receive this.