Northamptonshire County Council

Southfields House

Inspection report

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Date of inspection visit:
11 August 2020
12 August 2020

Date of publication:
22 September 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Southfields House is a care home providing care and support for older people and people with dementia. The service is separated into six units, three units provide short term care and rehabilitation and three units provide long term residential care. The service is registered to provide personal care to up to 45 people. At the time of inspection there were 23 people living in the home.

People's experience of using this service and what we found
The provider had quality control systems in place, however they were not effective, as required improvements had not been made in a timely way.

Quality improvement measures and oversight of medicines had been ineffective at driving enough improvement in this area. 'As required' medicine guidance for staff required further development to ensure people received their medicines as prescribed. Medicines records required improvement.

The provider did not always learn lessons when things went wrong; where audits had identified errors, action plans had not resulted in enough improvement.

Risks to people had not been effectively assessed and recorded, the provider had not maintained effective oversight of risks to people's health and well being. This included risks in relation to eating and drinking, pressure area care, hot water and fire. Records did not reflect that staff were supporting people in line with their care plans.

Food hygiene measures were not sufficient. People were at risk from food that had not been stored safely. Infection control procedures had not been fully implemented.

Recruitment procedures were not robust and did not ensure safe recruitment practices.

There were enough staff deployed to provide people with safe care. People's relatives and staff provided positive feedback about staffing levels.

People's relatives and staff told us that they felt supported by the management team and the registered manager was making improvements to the service.

Care records were person-centred and contained sufficient information about people's preferences, specific routines, their life history and interests. People and their representatives were involved in the planning of their care and given opportunities to feedback on the service they received. People's views were acted upon.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported

this practice.

Rating at last inspection
The last rating for this service was requires improvement (published 12 December 2019), the provider was in breach of regulation 17.

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines and pressure area care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed following this focused inspection and remains Requires Improvement.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Southfields House

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

Service and service type
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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Although we called the service five minutes before entering to discuss the effective management of any potential risks associated with Covid-19.

What we did before the inspection
We reviewed information we had received about the service. This included statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information we had received about the service from the local authority safeguarding team.

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.

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with two care staff, a shift lead and the registered manager.

We looked at five records about people's care needs and multiple medicines records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, accident and incident records and staff rotas.

After the inspection
We spoke on the telephone with five people's relatives, a supervisor, two care staff and a health care professional who works closely with staff to support people living in the home. We continued to seek clarification from the provider to validate evidence found. We looked at records relating to pressure area care, the environment, policies and procedures and infection control.

Requires Improvement

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 two inspections this key question has been rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● At the last inspection we found there had been a recent increase in medicines errors. At this inspection we found medicines errors continued to be a concern. We reviewed medicines errors records, for the four weeks before the inspection. These showed there had been ten medicines errors recorded. These ranged from recording errors to people not receiving their medicines as prescribed. The registered manager had investigated each error and was working closely with staff, the pharmacy and doctor's surgery to reduce medicines errors. However, people had continued to not receive their medicines as prescribed which put them at ongoing risk of harm.

● At the last inspection we identified there were no protocols in place for medicines that were prescribed 'as required'. At this inspection we found that 'as required' medicines protocols were implemented inconsistently. These were not in place for some people for medicines for pain management, constipation and shortness of breath. This meant that people continued to be at risk of not receiving their medicines as prescribed.

Assessing risk, safety monitoring and management

● Risks to people had not been effectively managed and reviewed.

● Where people had been identified as being at risk of choking, staff did not always follow their care plan. It was recorded in one person's care plan that they required a modified diet to reduce the risk of them choking. Staff had been providing the person with snacks that were not of the correct consistency. We discussed our concerns with staff and advice from a health care professional was sought. They advised it was safe for the person to have the food provided, however, staff had not identified they were not following the person's care plan and may be placing them at risk.

● Where people were at risk of dehydration, staff did not record on fluid records what action they had taken when people did not reach their daily fluid target. For example, recording they had shared this information with the next staff on shift so they could provide additional encouragement. This meant people's hydration could not be effectively monitored and action taken to reduce risk.

● Where people had been identified of being at risk of pressure sores, enough action was not always taken to mitigate the risk. Records did not reflect that people were supported to reposition as often as stated in their care plan. People's pressure area assessments had not been reviewed regularly, in some instances there had been gaps of many months. Although at the time of inspection these had all been reviewed recently.

● Improvements were needed to environmental safety; the provider had not implemented regular checks of the temperature of water accessible to people living in the home. People were at risk of scalding if water temperatures were too high.

● Fire safety checks and actions had not always been completed at the required frequency. Although weekly fire alarm testing was in place at the time of inspection, there was no record of this taking place between 27 March 2020 and 6 May 2020. This had not been identified or rectified in a timely manner.

Preventing and controlling infection

● People were at risk of being served food which had not been stored correctly and therefore may not be fit for consumption. We found opened food such as double cream, orange juice and bacon in fridges, these items had not been labelled with the date they had been opened and the use by date. Each unit in the home had a small kitchenette containing a fridge, temperature checks of the fridges showed the fridges were outside of the safe temperature range, but no action had been taken.

The provider had not ensured that all reasonably practicable steps were taken to mitigate risks to people and that people received their medicines as prescribed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received updated training in infection control. Protective personal equipment such as gloves and aprons were used by staff to prevent and control the risk of infection when providing personal care and support. However, we observed during the inspection that staff did not always use protective personal equipment in line with their training when in communal areas. This was discussed with the registered manager and addressed.

Staffing and recruitment

● The provider had not ensured safe staff recruitment procedures were consistently followed. Application forms were not fully completed to include, details of full work history and reasons for leaving. The registered manager was aware of staff's previous employment and told us this had been discussed with them but not recorded.

● Disclosure and Barring Service (DBS)checks were completed prior to staff working with people. The DBS 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. However, risk assessments were not completed in a timely manner in response to the findings of DBS checks.

● There were sufficient staff to meet people's needs and provide them with safe care. People's relatives told us staff had a good understanding of people's needs. One person's relative said, "In all my encounters with the staff they have been polite and kind, they have good communication, and nothing is too much trouble… they're lovely and helpful and all seem to know [family member] well." During the inspection we observed that staff had time to spend with people and had a good understanding of their needs.

Learning lessons when things go wrong

● The provider had been aware of ongoing concerns with medicines errors since the last inspection. They had been working with staff and partner agencies to make improvements. However, at the time of inspection not enough improvement had been made and medicines errors continued to occur.

● Accidents and incidents were recorded, the information was collated and analysed and used to inform measures to prevent incidents reoccurring. For example, when people had experienced falls, staff took appropriate measures to reduce the risk of re-occurrence.

Systems and processes to safeguard people from the risk of abuse

● All the relatives we spoke with said they felt that their family member was safe in the home. One person's relative said, "When I call, I appreciate their honesty, if [family member] has had a difficult day they tell me, [family member] is safe and it's a huge weight off my shoulders."

● People were protected from the risk of abuse. Staff were trained and knowledgeable around types of abuse, signs to look out for and how to report concerns. One member of staff said, "I know how to report it [safeguarding], initially to the manager but I could also go online and report it to the authorities, I would know how to do this."

Requires Improvement

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 two inspections this key question has been rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider's quality assurance systems and processes were ineffective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The service had not improved sufficiently at this inspection and the provider was still in breach of regulation 17.

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

- The provider had failed to implement effective governance systems or processes and had not effectively driven improvement in the quality and safety of the care being provided. The improvements required to the oversight of safety at the service had not been made.
- The improvements required to medicines management had not been implemented; there had been ongoing failings in medicine management. Oversight of medicines had not resulted in the necessary improvements and medicines audits were not consistently completed. Where audits had been undertaken insufficient action had been taken to address issues with medicines and medicines errors continued to happen.
- Oversight of medicines storage had not identified that staff did not take enough action when daily checks identified concerns. Medicines in use for people living on each unit were stored in cupboards on that unit. We reviewed temperature records on one unit and found they were above the identified safe range. Staff had recorded actions taken in response, but these were not effective as the temperature continued to be too high.
- The provider had failed to keep accurate, complete and contemporaneous records. Medicines records were inconsistently completed. For example, handwritten medicines records were not always signed by the staff completing them, cream charts did not contain the required information. We reviewed one person's medicine administration record which stated a medicine was to be given covertly (hidden in food and administered without the person being aware of it.) The registered manager told us this instruction was incorrect.
- There was a lack of oversight of pressure area care and nutritional risks and records. It had not been identified that staff did not consistently follow people's care plans, and records were inconsistently completed.
- The system to ensure new staff were safely recruited was not effectively implemented and this had not been identified in a timely way.

● Oversight of the environment and food safety was ineffective. It had not been identified that hot water temperatures were not being tested as required. Infection control policy and procedures had not been fully implemented. Although staff with specific health conditions had been provided with individual COVID-19 risk assessments this had not been extended to staff from black, Asian and minority ethnic backgrounds.

The provider did not have suitable systems in place to assess, monitor or mitigate risks relating to people's health and welfare. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance

● A new manager was in post, they had begun to make the improvements required to the service. They had a good understanding of the work that was needed and had made positive changes to improve the oversight and governance in place. These improvements now need to be embedded and sustained.
● Improvements had been made in some of the areas of concern identified at the last inspection. For example, improvements to mental capacity assessments and best interest decisions.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff and people's relatives spoke positively of the registered manager and provider and felt the service was working towards improving. One person's relative said, "It has improved a lot since the new manager started, she sorts things out. I have a lot of confidence in [Registered Manager]." A member of staff said, "The manager is very good, approachable and you can put forward your point of view, it's run well at the moment."
● All people's care plans had been recently reviewed. Information within care plans was person-centred and included up to date, relevant information around people's needs, their likes and dislikes, their life history and family relationships.
● Staff were knowledgeable about people who used the service and demonstrated they took a person-centred approach to providing care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager had a good understanding of their responsibility to be open and honest with people. The manager understood when they needed to report to the local authority and CQC.
● Staff understood and had been given information on the whistleblowing procedure and knew how to raise concerns with the local authority and care quality commission (CQC).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's relatives told us they felt involved in decisions and provision had been made to keep them involved during the recent limitations on visiting due to COVID-19. One person's relative told us how the registered manager had introduced a weekly telephone call to keep them informed of their family member's well being, they said, "[Person's name's] main carer is absolutely superb, I cannot fault her. She understands [family member] and calls me once a week so we can talk about how they are."
● The registered manager had also arranged for people's relatives to make video calls to the home to maintain contact with their loved ones.

Continuous learning and improving care; Working in partnership with others
● The registered manager and provider understood the need to maintain better oversight of the care provided and had an action plan in place to drive the improvements required.

● The registered manager and staff had worked in partnership with staff from the local GP practice to improve people's care. The health care professional deployed to support people in the home told us they believed improvements had been made and the registered manager and staff communicated with them well about people's health 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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been effectively assessed and recorded, the provider had not maintained effective oversight of risks to people's health and well being. This included risks in relation to eating and drinking, pressure area care, hot water and fire. Records did not reflect that staff were supporting people in line with their care plans.

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 17 HSCA RA Regulations 2014 Good governance The provider had quality control systems in place, however they were not effective, as required improvements had not been made in a timely way. Oversight of medicines and quality improvement measures had been ineffective at driving enough improvement in this area. 'As required' medicine guidance for staff required further development to ensure people received their medicines as prescribed. Medicines records required improvement. The provider did not always learn lessons when things went wrong; where audits had identified errors, action plans had not resulted in enough improvement.

The enforcement action we took:

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