Tamaris Healthcare (England) Limited

Southfield Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Southfield Court Care Home took place on 9 and 24 March 2016. Both visits were unannounced. We previously inspected the service on 8 and 10 August 2015 and at that time we found the provider was not meeting the regulations relating to premises safety, administration of medicines, staff training and supervision and keeping accurate records. We asked the registered provider to make improvements. On this visit we checked to see if improvements had been made.

Southfield Court is a purpose built care home providing accommodation and nursing care for up to 50 older people, some of whom are living with dementia. There were 46 people using the service on the first day of our inspection and 39 people on the second day.

The service is required to have a registered manager. There had been no registered manager at the home since 8 April 2015. 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.

A temporary peripatetic manager had been managing the service until August 2015, when a new permanent manager came into post. This manager left the service in January 2016 and since that time three peripatetic managers had managed the service. At the time of inspection a new manager had been appointed and was in post on the second day of our inspection.

People who used the service we spoke with were unable to tell us if they felt safe due to cognitive or sensory impairment, however the visitors we spoke with told us they felt their relative was safe at Southfield Court.

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to the safety of premises. The provider sent us an action plan outlining the improvements they would make. At this inspection we found people were still not protected against the risks of unsafe or unsuitable premises because the necessary safety checks were not being regularly completed and we found the service was still not meeting this requirement. This was a breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with told us they were unhappy with the number of different agency staff at the service, leading to a lack of consistent care for their relative. We found there were not always enough experienced staff available to respond to people who required assistance in a timely manner. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to the management of medicines. On this inspection we checked and found improvements had not been made. This was a breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014, safe management of medicines

We found poor practice in the prevention and control of infections. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to supporting staff. On this inspection we checked and found improvements had not been made. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's capacity was considered when decisions needed to be made. This helped ensure people's rights were protected when decisions needed to be made.

People told us they enjoyed the food and we observed staff supporting people to eat and drink. People had access to external health professionals as the need arose.

We observed staff interacting with people in a caring, friendly and professional manner. Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for and supported.

The home employed an activities organiser to organise and enable people to participate in activities. However; there was a lack of meaningful activities for a number of people who lived at the home. People did not always receive care that was planned to meet their assessed needs. These issues were a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to make choices about their care. Peoples care plans detailed the care and support they required and included information about peoples likes and dislikes, however there were some gaps in recording.

Relatives told us they knew how to complain and told us staff were always approachable. Comments and complaints people made were responded to appropriately.

Relatives we spoke with felt consistent management had not been in place for some time and they were unhappy with the lack of direction and consistency for their relative.

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to keeping accurate records. On this inspection we checked and found improvements had not been made. This was a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered provider had a system in place to audit and monitor the service to check whether the service provided was to a high standard, however this system was not effective and had not picked up and addressed the problems we found at the last inspection in August 2015.
This was a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service held meetings with staff, and the relatives of people who lived at the home to gain feedback about the service provided to people.

On the second day of our inspection the new manager was actively addressing the issues we found. However, it was too early to say if improvements would be sustained.

You can see what action we told the provider to take in relation to the breaches in the regulations at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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 always safe.

People were not always protected against the risks of unsafe or unsuitable premises.

There were not always enough experienced staff available to respond to people in a timely manner

People's medicines were not always managed safely

People were not always protected by effective infection prevention and control practices.

Is the service effective?

Requires Improvement

The service was not always effective

Staff were not always provided with training and supervision to ensure they were able to meet people's needs effectively

People's consent to care and treatment was sought in line with legislation and guidance.

People were supported to eat and drink and maintain a balanced diet

People had access to external health professionals as the need arose

Is the service caring?

Good

The service was caring.

Feedback from people and their relatives was that staff were caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

People were supported to make choices and decisions about their daily lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always organised and delivered in a person centred way.

Activities were provided but this was not at a level which would meet the needs of all the people living at the home.

People and their representatives were involved in the development and the review of their support plans

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Inadequate

The service was not always well led

People told us the management of the service had been inconsistent in recent months

Accurate records were not always maintained

The registered provider monitored the quality of the service, but the systems had not picked up and addressed the problems we evidenced in our report.

Southfield Court Care Home

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 inspection took place on 9 and 24 March 2016. The visit on 9 March 2016 was unannounced. Our visit on 9 March consisted of three adult social care inspectors. Our visit on 24 March consisted of one adult social care inspector.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about poor staffing levels at the home and a lack of management

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. Not all the people who used the service were able to communicate verbally, and as we were not familiar with everyone's way of communicating we used observation as a means of gauging their experience.

On the first day of our inspection there had been an outbreak of an infectious illness at the service. We did not speak to people who used the service and visitors until the second day of our inspection when the infection was no longer present.

We spoke with five people who used the service and seven visitors. We spent time in the lounge areas and dining rooms on both units observing the care and support people received. We also spoke with eleven members of staff as well as the peripatetic manager, the area manager, the new manager and the new deputy manager. We looked in the bedrooms of eight people with permission. During our visit we spent

time looking at 17 people's care and support records. We also looked at two records relating to staff recruitment, training records, maintenance records, and a selection of audits.

Inadequate

Is the service safe?

Our findings

People who used the service we spoke with were unable to express whether they felt safe due to cognitive or communication difficulties and complex needs. The visitors we spoke with told us they felt their relative was safe at Southfield Court. Visitors said "Generally it's safe, but there has been no manager to discuss it with." Visitors we spoke with told us if they had any concerns about the way their relative or friend had been treated they would talk to the staff team about it.

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to safe premises (12, 2 d) because the service had not carried out the necessary fire safety checks which ensured people were kept safe. The provider sent us an action plan outlining the improvements they would make. At this inspection we checked to see if improvement had been made.

We looked at the health and safety check book and the fire safety check book for the service. The home employed a maintenance person who carried out safety checks within the home. In the fire safety book we saw checks had not been carried out in line with the policy of the service. For example, there was no record of checks on emergency lights between November 2015 and January 2016 and no record of checks on fire doors recorded. Fire alarm system checks had not been completed on a regular basis. We asked the new manager about this, they told us they would address this. However this problem had not been noted or addressed prior to the new manager commencing employment with the service two weeks previously. This meant people who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

The above issues demonstrated a continuing breach of regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider did not ensure the premises was safe for use by people who used the service.

We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). A series of risk assessments were in place relating to health and safety. We saw suitable equipment was in place to meet the assessed needs of people who used the service for example: profiling beds, pressure relieving cushions, sensor mats and hoists. We saw equipment was regularly serviced.

The relatives and visitors we spoke with told us there were not always enough staff available to respond to people who required assistance in a timely manner. One relative said "Finding a carer is quite an issue at times. My relative asked for a drink and an hour later no drink had arrived." Another relative told us "There are no carers about. On many occasions you look for someone to ask and there is never anyone about." A further relative told us "They seem to be low on staff often to say there are so many that need one to one care at lunch times."

The area manager told us there were generally enough staff, but told us they had a number of staff vacancies they were currently recruiting to. They showed us a tool which was used to determine the staffing

levels required according to the level of people's' needs and this tallied with the number of staff on the duty rota and present on the days of our inspection. Four people who used the service had additional carer staff from an outside care agency to provide one to one support during the day in line with their assessed needs. Since our last inspection the home had begun to use senior carers who had completed additional health related training, known as Care Home Advanced Practitioners (CHAP), to lead the shift on one unit and sometimes only one qualified nurse was on duty across the service during the day.

There were not always enough experienced staff to meet people's needs and keep them safe. Relatives told us there had been high use of agency staff in recent months, who didn't know their relatives needs and this caused problems for their relatives with continuity of care. One relative told us "At the moment there are quite a lot of different people." Another relative said, "Every day there is a new face. Last week there was an agency nurse on duty and other staff I didn't know." They told us their relative refused to have unfamiliar people in their room and so had difficulty getting the care they needed when all the staff were unfamiliar. We discussed this with the manager who accepted it was a problem and was trying to recruit permanent staff.

One member of staff told us, "Yes there are enough staff, but it is difficult with agency staff if they don't know the residents." One member of staff told us they had worked a night shift recently where all the staff were from an agency. We saw on 26 and 28 February 2016 both qualified nurses on night duty were from an agency. On 23 February three night staff were from an agency. On 29 February both night nurses were from an agency and on 1 March all four night staff were agency staff. This meant there was a risk of inappropriate care being delivered because care staff were not familiar with people's needs.

On 24 March lunch commenced at 12.30 and people who were supported to eat in their rooms had not begun to be supported to eat by 1.10pm. One person was being supported to eat in their room after 1.45pm when appropriate staff had been found to support the person to reposition.

We observed an agency member of staff come to support a person with lunch in their room at 1.45pm. As the agency carer was not familiar with the person's needs they called for assistance and another agency carer was deployed who was not familiar with the person and their moving and repositioning needs. After another five minutes a regular carer came. This delayed the persons support because agency carers did not know the person's needs. This meant sufficient appropriately experienced staff were not always deployed to meet the needs of people who used the service.

The above issues evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection the new manager told us they had prioritised the recruitment of new permanent staff in order to improve the experience of people who used the service and were awaiting pre-employment checks for several new staff members.

Our previous inspection found the registered provider was not meeting the regulations relating to the management of medicines because the recording of the receipt and administration of people's medicines was not always accurate. On this visit we checked and found improvements had not been made.

Medicines were administered to people by registered nurses and senior carers, or in the case of topical creams by trained care staff. Most medicine was administered from a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medicines which had not been dispensed in the monitored dosage system(MDS)

We looked at medicines administration procedures in the home. The nurse we spoke with showed us the medication administration records (MAR) sheets, which were largely complete but contained gaps in signatures.

We carried out a random sample of 10 supplied medicines dispensed in individual boxes. We found one error in counting. On three further occasions we found errors which indicated medicines had been administered but not accounted for or signed as administered and not given.

The above issues evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We witnessed some poor practices in the administration of medicines. We saw a number of people had been prescribed 'Thick and Easy' to thicken fluids. Whilst all people had the product individually dispensed we witnessed two people using one person's dispensed item.

We looked at the provider's medicines policy. The policy demonstrated the provider had taken some steps to ensure they complied with current legislation and best practice in the administration of medicines. We saw any known allergies were recorded. The provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, we saw protocols were available for the administration of warfarin where the dose is determined by periodic blood tests.

We looked at medicines storage. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge and clinical room temperatures were taken daily and recorded. We found the treatment rooms were locked when not in use.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. We observed the preparation of an injectable controlled medicine. The giving of the medicine and the balance remaining was checked by two registered nurses.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. Liquid medicines were dated upon opening. All medication was found to be in date.

We saw all 'as necessary' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

One person had their medicines administered covertly. Covert administration of medication occurs when medication has been deliberately disguised, usually in food or drink, in order that the person does not realise they are taking it. The person's care records showed correct procedures had been applied to ensure the medicines were administered within current guidelines.

On 9 March when we arrived at Southfield Court a sign on the door stated an infection was present in the home and people could enter at their own discretion. The managers we spoke with on the first day of our inspection were not clear who had the infection and how long they had been affected. The peripatetic manager gathered this information later in the morning to share with CQC and with Kirklees Council Infection Prevention and Control (IPC) team, who had been notified of the infection by the home the previous day (8 March). The infection had begun on the previous Friday 4 March 2016 and should have been

notified to IPC at that time; however procedures had not been followed to prevent the spread of infection in line with agreed policy.

On 9 March on entering the home we found a strong mal odour in the foyer, throughout the communal area of the home, as well as in individual bedrooms. On 24 March the odour in the foyer was improved, following a deep clean; however the mal odour in the corridor and lounge on one unit was still present. We found soiling on showering equipment and a lack of Personal protective equipment (PPE) for staff to ensure good infection control practices.

We found an assisted bath in poor repair and some of the doors and walls in the home were dirty and sticky. The door to the utility room was dirty and in poor decorative order.

We were told during our inspection less cleaning hours had been going into the home since December 2015, as cleaners were covering for long term staff absence and deep cleaning had been reduced as a result.

We observed staff commencing personal care and administration of medicines without using PPE. On one unit, where the infection was present, we saw two care staff took linen into a person's room to support them with personal care. The trolley in the corridor contained used bedding. We saw one person who used the service who was living with dementia walking around the corridor unsupported. We discussed this with the peripatetic manager. We were later informed the person in the corridor was already affected by the infection. This evidenced poor practice in infection prevention and control.

The above issues were a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the service did not always protect people by preventing and controlling infection.

We subsequently limited our inspection, which was on-going, on 9 March to Beech unit, where the infection was not present and terminated the inspection early. We contacted the local authority infection prevention and control (IPC) department regarding our concerns and an IPC visit was carried out that week and advice given. We returned to complete our inspection when the infection was under control and PPE was seen to be worn. A deep clean of the home had been completed.

The managers, nurses and staff members we spoke with had a good understanding of safeguarding and the procedures to follow to keep people safe. We spoke with six staff members about this. They told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. Staff gave us a description of the different types of abuse they may come across in their work. This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw safeguarding incidents had been responded to appropriately and action taken to keep people who used the service safe. We saw the home had a safeguarding policy which was visible around the home. This demonstrated the home had robust procedures in place for identifying and following up allegations of abuse, and staff demonstrated knowledge of the procedures to follow.

We looked at the care records of nine people who used the service and saw comprehensive risk assessments were in place for a range of issues including hydration and nutrition, mobility and falls, skin integrity and choking. We saw these assessments were reviewed regularly, signed and up to date. The regular members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence.

Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. The manager or nurse on duty recorded all incidents or accidents on the computer system. We saw this included action taken to reduce the risk and immediate action taken to keep the person involved safe. The new manager and nurses on duty were able to confidently describe the procedure to follow and what action had been taken following incidents to prevent them from happening again.

We saw the registered provider had a system in place for analysing accidents and incidents to look for themes and lessons learned. This demonstrated they were keeping an overview of the safety in the home.

We looked at three staff files to check that procedures had been followed to make sure staff employed at the home were suitable to work with vulnerable people. We saw staff members had completed an application form and references had been sought. We found that the Disclosure and Barring Service (DBS) had been contacted before they started work at the home. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. This meant there was a system in place to ensure staff remained suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to staffing because staff were not always provided with training, supervision and appraisal to ensure they were able to meet people's needs effectively. At this inspection we found staff were still not provided with appropriate supervision and support.

The staff we spoke with told us they had completed induction training when they started working at Southfield Court. They told us they shadowed more experienced staff for about three shifts before being included on the duty rota. The members of care staff we spoke with told us they had completed e-learning in moving and handling, infection prevention and control, pressure area care, dementia, first aid, food hygiene, fire safety, mental capacity and safeguarding. Staff said the training was useful and gave them the skills and knowledge to do their job, although a staff survey completed by the service in January 2016 noted some staff did not feel they had the knowledge they needed.

We saw on the homes computer system mandatory training updates were largely over 70% complete, however in some areas such as moving and handling theory, training was only 67% complete. This showed us some staff may not have the skills and knowledge required to do their job effectively as some of their essential training was not up to date. We did not, however, note any concerns with the moving and handling we observed.

Staff we spoke with said, "In general I feel supported. I always speak to the nurse." "Any problems I address with the nurses." Staff did not always receive regular management supervision to monitor their performance and development needs. The home's policy stated supervision should take place six times a year including one appraisal. On the first day of our inspection supervision records could not be located. On the second day of our inspection the new manager showed us the supervision records they had located and logged.

Supervision had been conducted only in response to particular issues or concerns and had not been planned on a regular basis to provide support and professional development to staff. Some supervision records were identical printed sheets, signed by staff, used to evidence a particular issue had been discussed. One staff member had supervision recorded in March 2016, again reacting to a specific concern. We saw no record of supervision for one nurse since May 2015.
Only one supervision record was seen which showed evidence the service was using supervision to monitor performance and development. This meant staff did not receive regular management supervision to monitor their performance and development needs and ensure they had the skills and competencies to meet people's needs.

This represented a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The new manager planned to introduce a more pro-active approach to staff support and professional development. They had taken in hand the probationary support for new starters which had not been

addressed in the absence of a permanent manager.

The registered provider had policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are 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 were being met.

We spoke with a nurse who told us of three people with authorised DoLS in place. Scrutiny of the granted authorisations showed no conditions applied. Our discussion with the nurse showed they knew of the possibility of conditions being made upon granting of DoLS and they knew these had to be translated into effective care planning.

We saw where necessary all people had been assessed regarding their mental capacity to make their own decisions. The assessments were specific to the situation being assessed. For example, we saw one person had been assessed to judge their capacity to self-administer medicine. On another occasion we saw an assessment had been conducted before considering fitting an alarm to a person's bedroom door' which also preceded seeking authorisation of DoLS. Our discussions with the peripatetic manager and staff showed they had a good understanding of the MCA and issues relating to consent. One member of staff we spoke with said, "If I had any concerns about someone's capacity to make decisions I would talk to the nurse."

We spoke with a senior care worker about the use of restraint which included the use of bed-rails. We saw a number of people had bed-rails in place. Scrutiny of one person's care plans demonstrated a risk assessment had been completed prior to the use of bed-rails. The risk assessment showed the person was at risk of rolling out of bed and the use of the bed-rail was to protect the person from harm. The senior care worker had a clear understanding of how bed-rails should not be used to confine people to bed and as such would constitute illegal restraint.

We observed a person in the lounge who was seated in a chair being tipped slightly backwards. We looked at the person's care plans to find health needs assessments had taken place which identified the need for the observed posture to be maintained. Therefore whilst the chair restricted the person's movements the chair was not being used for the purpose of restraint. We also saw the person was awaiting an occupational therapist visit to assess whether the chair being utilised was appropriate to maintain posture or whether a bespoke chair would be more appropriate. This meant that the human rights of people who used the service were protected and they were not unlawfully restrained.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

People at Southfield Court were supported to have sufficient to eat, and drink and to maintain a balanced diet. Visitors told us, "They do their best to encourage them (person) to eat" "(person) had lost a lot of weight

and is given extra foods like yogurt and bananas, but food is often left. They could do with some more support. They need encouraging and supporting to eat."

The catering service had been outsourced to a separate company and arrangements had been changed to a lighter lunch and a bigger meal at tea time, due to many people who used the service not being as hungry at lunch time, with the aim of improving nutritional intake and reducing food waste. The people who used the service that we spoke with who were able to do so told us they enjoyed the food.

We observed lunch in the dining room on one unit on the first day of our inspection. There was a choice of two light lunch meals, jacket potato and baked beans or carrot and coriander soup. The jacket potato option looked dry and no butter was offered, even though the people we observed were at risk of weight loss. We discussed this with the peripatetic manager who said they would address it with the catering service. On 24 March we spoke with the chef, who was aware of people's special dietary requirements and told us all the meals were fortified, for example cream was added to the vegetable soup which was on the menu that day.

We saw staff supported and encouraged people to eat and drink. Interactions between staff and people were friendly, respectful and supportive. People were not rushed with their food, and drinks were available throughout the day.

The nurse on duty told us people were weighed either weekly or monthly dependent on risk. If weight loss occurred they informed the family and referred the person to the GP. The weight of all the people was recorded on the monthly observation reports to managers and a spread sheet of people's weight across the year could be viewed to look for any concerns. The regional manager told us the system highlighted any issues of concern such as weight loss in red to make it clearer when action was required.

We looked at the care records of two people who were at risk of weight loss. In one care file the person's weight was recorded on 9 February 2016 as 44KG. On 13 March 2016 the weight was recorded as 39.2KG. We asked the senior carer in charge about this. The carer felt this was incorrect, as the person did not appear visually to have lost weight and they believed the person weighing them must have used the hoist scales incorrectly. They weighed the person that day and found the weight to be 45.7KG. The senior carer said the staff member who weighed the person was an agency member of staff and they would address this with them. However this apparent weight loss had not been acted on or checked prior to the inspection. This meant the person was at risk of inappropriate care because weight was not being monitored in line with their assessed needs.

Daily food and drink intake was recorded in a daily record which was either kept in the person's room or in the nurses' office. In one person's room records were up to date and recorded what the person had eaten and changes in position in line with their care plan. In another person's records there were gaps in recording on a number of occasions. Recording nutritional intake was an important component of the persons care due to a long term health condition. The above issues meant people may be at risk of inappropriate care because accurate and appropriate records were not always maintained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at Southfield Court were supported to access healthcare. A visitor said, "They call me at home if there's any problem, and if I'm worried I talk to the carers or the nurses. They are very good." We saw appropriate medical attention was sought when people showed signs of ill health. The GP visited a number

of people during our visit. The nurses we spoke with said the home had a good relationship with local GP's. We saw in the care files of people they had regular access to health services, such as the optician, GP, chiropodist, district nurse and falls team. This showed people received additional support when required for meeting their care and treatment needs.

We saw the environment of one unit had been designed to support people living with dementia to live well, although it was in poor decorative condition. Handrails were available along all the corridors to aid mobility. The corridors on Beech unit had themes for orientation and stimulation, such as music, gardens, the library, seaside, hobbies and interests. The colour of the bathroom and toilet doors was identical and different to the colour of all the bedroom doors for identification and orientation. People's bedrooms were numbered and named with a life history about each person on display outside their room and people's bedrooms were personalised to make them feel homely and comfortable.

Good

Is the service caring?

Our findings

The service was caring. One person who used the service said, "It's good. They are caring." One visitor told us "The carers are pleasant." Another said, "The three or four regular staff, they are very, very good." "Individual staff are caring. It's not the easiest job."

During our inspection we observed staff speaking with people in a kind, caring and respectful manner. Visitors told us they could 'come and go' as they pleased and that they were kept informed of things that happened to their relative when they weren't there. Regular staff clearly knew residents and visitors well.

Staff we spoke with enjoyed working at the home and supporting people who used the service. One staff member told us "I enjoy looking after the residents. Feeling I do my best. It's rewarding. I try to be jolly for the residents and relatives."

On the second day of our inspection we saw staff sit down next to a person and spend time talking to them. We saw their interaction was warm and respectful. We heard staff speak with people in a kind and caring way whilst supporting them to eat and also when offering a choice of meal and drink.

People were supported to make choices and decisions about their daily lives. We saw care files contained information about their tastes and preferences in the 'this is me' section. There was a section on lifestyle choices and a communication care plan which indicated how people could be supported to communicate their preferences. Regular staff we spoke with had a good understanding of the needs of people. The care plans had a personal history of the person. This gave staff a rounded picture of the person and their life and personal history before they went to stay in the home. This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. Staff said, "Speak to the person whilst you assist them. Try to gain consent before assisting. Cover the person during personal care." We saw that whilst people were using the hoist to transfer, staff spoke encouragingly and reassuringly to them and informed them what they were doing and why. We saw staff knock on people's doors before they entered and speak with people in a respectful way.

An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves. Leaflets were present in the home with details of available advocacy services and we saw from records people had been referred for advocacy services when required.

People were encouraged to do as much as possible for themselves in their daily life. For example, holding their cup or utensils when being supported to eat and drink. This showed people using the service were encouraged to maintain their independence

Requires Improvement

Is the service responsive?

Our findings

People at Southfield Court did not always receive personalised care that was responsive to their needs. Most staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. However, agency staff were not always familiar with people's needs.

Some people had been assessed as being at risk of developing pressure ulcers and required regular repositioning. We looked at the repositioning chart for two people who used the service. We found errors in one person's recording of pressure care management and both permanent and temporary staff did not know how often this person should be repositioned in line with their pressure care plan. This meant we could not be assured the person was receiving care in line with their assessed needs.

Activities were provided at Southfield Court but this was not at a level which would meet the needs of all the people living at the home. One visitor said, "No one is taken for any activities, or for a walk up and down the corridor."

An activity coordinator was contracted for 23 hours. We saw they played dominoes with a person in the lounge and later came in to the lounge on Beech Unit to draw the Easter raffle. Another activity coordinator vacancy for 18 hours had been filled but the person had not yet started in the role.

A record of activities was kept in people's daily records. On 24 March we saw the last entry in one person's activity record was on 9 March. The carer told us an entry should be made every day. Enabling people who are living with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

The above issues evidenced a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not always receive care that was planned to meet their individual needs.

We saw in the care files of people that their preferences and interests were recorded. We saw care plans were person centred and provided information about the individual that would enable them to receive person centred support, for example, how a person liked to have their pillows positioned and what a person liked to wear in bed. We saw one person was wearing their t-shirt in bed in line with their recorded preference. This is important as some of the people who used the service had memory impairments and were not always able to communicate their preferences.

Care plans covered areas such as mobility, hygiene, communication, continence, skin integrity, rights, finances, relationships, cognition and emotional needs. Care plans had been reviewed monthly by the nurse or Senior carer on duty We saw two care files on one unit had not yet been updated since February 2016. Reviews helped in monitoring whether care records reflected people's current needs so that any necessary

actions could be identified at an early stage. We saw changes to the care plans had been made as necessary following changes in the person's needs. This showed care planning took account of people's changing care needs.

We observed staff offering choices. This showed that the service responded to the preferences of people who use the service. Some relatives we spoke with told us they were included in care plans and reviews and they felt informed of developments in their relative's condition. Relatives and visitors said, "The nurses are very good. They keep in touch and ring me up." "I have only been to one review in two years, a few months ago. We asked about reviews at the relatives meeting, so they did us all."

Staff told us there was a handover between all shifts. A handover sheet was used to give agency staff basic information about each person, their room number, if the person needed hoisting, health needs and any key information.

People who used the service we spoke with were not able to tell us about raising concerns due to cognitive or communication difficulties and complex needs. The relatives we spoke with told us they would feel comfortable raising issues and concerns with any of the staff, but were not aware who was managing the service at the moment. We looked in the complaints and compliments log for the home. We saw complaints had been responded to appropriately and action taken to address concerns. For example: One complaint by a relative that a person wasn't up and supported to dress for the day was responded to by a flash meeting with staff to ensure the person was appropriately supported.

The new manager said if people were not happy with any aspect of the service they could talk to her and she would deal with it straight away.

Inadequate

Is the service well-led?

Our findings

The home was not always well led. One relative said, "There has been about three or four managers. I don't know who the manager is. I come here most days. It is terrible."
Another relative we spoke with said, "I think it's good. We have a new manager. Let's see what happens."

There had been no registered manager at the service since 8 April 2015. A temporary peripatetic manager had been managing the service until August 2015, when a new permanent manager came into post. This manager left the service in January 2016 and since that time three peripatetic managers had managed the service. At the time of inspection a new manager had been appointed and was in post on the second day of our inspection.

The staff we spoke with looked forward to having a regular manager in place. They told us they felt the service had been impacted upon because there hadn't been a manager in place for some months. One said, "It's difficult not having a regular manager. Nurses have done their very best."

Our inspection on 8 and 10 August 2015 found the registered provider was not meeting the regulations relating to keeping accurate records. On this inspection we checked and found accurate records were still not always maintained in relation to care that was being delivered.

We saw from the daily journal in two people's bedroom that their daily food and drink intake was monitored, as well as position changes, the person's mood and any interactions with staff or activities. We saw in one person's records at 1.45pm the person's room check stated the person should be checked every hour, as they were based in bed. The last recorded room check was 9.47am and breakfast was recorded at 10.17am. We saw on 20 March 2016 the room check was recorded at 9.20am, and 14.54pm. This meant the provider could not demonstrate the person was receiving care in line with their assessed needs.

We saw there were gaps in the recording of food and fluid intake for one person who was living with diabetes. We spoke with the persons relative who told us their relative was often reluctant to take food or drink and the nurses were normally very good and encouraged their relative to eat, however just prior to their relative being admitted to hospital with low blood sugar they had noticed no familiar staff were on duty. We spoke to the nurse and senior carer on duty about this. They told us agency staff had been on duty and may have omitted to record food intake. The nurse on duty agreed to follow this up with staff. We asked the nurse on duty how records were checked to ensure nutritional intake was recorded and they told us they randomly sampled records and addressed any issues with staff. The nurse on duty told us they had not recorded these random samples of records or conversations with staff. This meant people who used the service may be at risk of inappropriate care because accurate records were not always maintained.

This was a continued breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection a peripatetic manager was on duty. The manager was not able to locate

some of the information required and was not aware of who was affected by the viral infection affecting people who used the service.

We found there were gaps in the way the registered provider monitored the overall service. We saw a quality meeting held in January 2016 identified gaps in documentation and stated these should be checked by the manager or shift leader at the end of every shift, however there was no evidence these checks had taken place, or any gaps in recording followed up with relevant staff.

On the second day of our inspection, 24 March 2016, we found one persons en suite toilet had been blocked for the last three days. The relative had reported it to the maintenance person on 21 March, but no action had been taken. The inspector discussed this with the new manager. The new manager called maintenance to rectify the problem and it was rectified later that day. The manager apologised to the relative. However this demonstrated effective systems were not in place to ensure building safety and maintenance were maintained and the problems had not been picked up or addressed by the providers audit systems.

We asked the area manager about practical moving and handling training and they told us staff had completed 2 days training in moving and handling conducted by a senior carer at the home, but this was not recorded on the computer system and manual records could not be found. On the second day of our inspection the manager showed us registers from practical moving and handling training with the signatures of 11 members of staff and told us more sessions had been arranged. As these staff members training records were not updated on the system the computer system was not an accurate record of training completed. This would make it difficult to ensure the training needs of staff were monitored and addressed.

We found continuing breaches of the regulations relating to safe use of the premises, management of medicines, supervision and appraisal for staff and keeping accurate records, which had not been addressed since our last inspection on 8 and 10 August 2015. No improvements had been made and further concerns were found relating to infection prevention and control practices and deploying sufficiently experienced staff. The registered provider had not addressed the problems we found and, as information was not being routinely collated and analysed we concluded the provider was failing to effectively assess and monitor the quality and safety of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because effective systems were not in place to assess, monitor and improve the quality and safety of the service provided.

Meetings with staff, people who live at the home and their relatives are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care. We saw relatives meetings had been held regularly and were organised by relatives themselves. The manager on duty attended for part of the time, to hear any concerns raised. One visitor told us, "I go to all the relatives meetings. I have found it very helpful. They meet every month. When concerns have been raised things have improved."

Staff meetings were usually held every month. Topics discussed included staff training, and completing room recording. Actions from the last meeting were discussed and goals were set from the meeting. The new manager was holding a staff meeting on the second day of our inspection.

We asked the area manager and new manager how they gained the views of people who used the service or their representatives. The area manager told us, "I walk round and talk to people. They can also use the ipad in the foyer to feedback." The area manager told us relatives had been involved in recruiting the new home

manager. A system was in place to ensure formal feedback from relatives and people who use the service was acted on. All feedback on the ipad system from 26 January 2016 until 7 March 2016 was over 90 percent positive. We saw any results lower than 70% positive elicited an email to the home manager to address the issues. This demonstrated a system was in place to respond to people's views and experiences , however managers were not aware of or had not addressed the concerns expressed to us by relatives during our inspection.

We asked the managers on duty about audits at the home. We were shown the home's audit schedule. A variety of checks were carried out on a monthly basis by the managers and nurses on duty including observing lunch, hoist and sling checks, mattress checks, updating the needs and staffing level assessment and evaluation of care plans. We saw mattress audits were completed regularly and mattresses replaced when necessary. We saw a regional manager had visited the service regularly and completed some audits of care files and medicines, as well as a 'walk round' of the service, however the problems we found at the last inspection had not been addressed.

On the second day of our inspection the new manager and deputy manager had commenced employment with the service. They had begun to address the issues relating to staff vacancies and the use of agency staff by recruiting new care staff and nurses. They had arranged for the home to be deep cleaned and arranged a meeting with staff and relatives. They had audited supervision, training and recruitment files. This meant the new manager was pro-active in stabilising the staffing at the home and addressing the issues we found however, it was too early to say if any improvements would be sustained.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was planned to meet their individual needs and preferences. 9 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of people who use the service Regulation 18 2 (a) Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected against the risks of unsafe or unsuitable premises Regulation 12 (2)(d) Medicines were not always administered in a safe way for service users Regulation 12 (2)(G) The service did not protect people by preventing and controlling infection. Regulation 12 (2) (h)

The enforcement action we took:

Warning notice served to comply by 20 June 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service provided to people who use the service. Regulation 17 (2) (a) Accurate records were not always maintained in respect of each service user. Regulation 17 (2)(c)

The enforcement action we took:

Warning notice served to comply by 20 June 2016