Tamaris Healthcare (England) Limited

Southfield Court Care Home

Inspection report

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Date of inspection visit:
18 July 2017
20 July 2017
21 July 2017

Date of publication:
27 June 2018

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

We inspected Southfield Court Care Home (known as 'Southfield Court' to the people who live and work there) on 18, 20 and 21 July 2017. The first day of the inspection was unannounced. This meant the home did not know we were coming.

Southfield Court is a care home registered to provide nursing and residential care for up to 50 people. It consists of one building with two floors accessed by passenger lifts. All rooms are single with ensuite facilities. There were 44 people living at the home at the time of this inspection.

Each floor of the home has lounge areas, a dining area and shared bathrooms and toilets. There is an enclosed garden area to the rear of the building, but it had not been tended for some months prior to this inspection and was therefore not used by people.

Southfield Court was last inspected in December 2016. At that time the home was rated as Requires Improvement overall as it was deemed to be Requires Improvement in the key questions of Safe, Responsive and Well-led, and Good in key questions of Effective and Caring. We served two warning notices after the inspection in relation to continuous breaches of the regulations relating to person-centred care and staffing. We also asked the registered provider to send us an action plan to tell us how they were going to tackle a continuous breach of the regulation relating to good governance.

At this inspection we found some improvements had been made, but identified other concerns. We found continuous breaches of the regulations relating to staffing and good governance, and new breaches of the regulations relating to safe care and treatment, and safeguarding people.

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 home had a registered manager. At the time of this inspection she had been on a period of extended leave since November 2016 and had started working two days a week commencing the week before this inspection, in preparation for returning to work four days a week in August 2017. During the registered manager's absence the deputy manager had been the acting manager, with support from various staff from the registered provider.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Feedback from people and relatives about staffing levels was mixed. The number of staff deployed had increased as 17 people were admitted between April and May 2017. The home aimed to staff at levels higher than required by the dependency tool used but we saw this was not always effective. We observed people in communal areas for periods of time with limited staff interaction.

People and their relatives told us the home was clean. We noted occasional smells which did not persist. During the week of this inspection soap in a person's ensuite bathroom had run out for two nights and one day, which meant staff had not washed their hands when supporting the person with care during this time.

Not all risks to people had been assessed and managed appropriately. The settings of air mattresses used by people to reduce their pressure ulcer risk were not in their care plans and staff did not know what they should be. Measures put in place to safeguard people from others who experienced behaviours which may challenge were not always effective.

Most aspects of medicines management and administration had been done safely. We identified some issues which the acting manager said they would address immediately.

Most care plans we sampled were detailed and person-centred, although others were not. We identified inconsistencies between some people's care plans which made it difficult to understand what their needs were.

Our observations and records showed people's access to meaningful activities was limited. This was a finding at the last inspection in December 2016.

Complaints made by people and their relatives had been managed and responded to appropriately.

Staff employed by the home had access to the induction, training and supervision they needed to provide effective care to people. Records showed none of the agency staff used in 2017 had received an induction to the home.

The acting manager had contacted relatives to request evidence of any Lasting Power of Attorney they held for people at the home. Mental capacity assessments and best interest decisions were in place for most people, but we did identify some gaps. People who needed Deprivation of Liberty Safeguards authorisations had them in place.

Most feedback about the food and drinks at the home was positive. Staff at the home, including the chef, were knowledgeable about people's dietary needs.

Records showed, and people's relatives told us, they had access to a range of healthcare professionals in order to help support their holistic health needs.

People and their relatives told us permanent staff at the home respected people's privacy and dignity, and promoted their independence. We observed interactions between staff and people which were warm and caring.

Care staff knew people well as individuals and had developed good relationships with relatives who visited regularly. Most people and relatives said they had been involved in care planning but this was not evident in care records. The registered manager said she would address this.

Care staff could describe what was important in terms of good end of life care. End of life care had been discussed at a residents' and relatives' meeting in 2017; a healthcare professional from the community team had attended to share information about end of life care and answer questions.

Efforts to drive improvement at the home since the last inspection by the registered provider had not been effective. We saw measures had been put in place to address concerns in the weeks prior to this inspection, but they had yet to take effect.

A range of audits were in place to monitor the safety and quality of the service. Representatives of the provider visited the home regularly and had oversight of the service provided and any concerns raised.

People, their relatives and staff were provided with opportunities to feedback about the service and how any feedback had been acted upon was communicated back to them by the provider.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Feedback from people and their relatives about staffing levels was mixed; we observed periods of time when people had limited interaction with staff.

Risks to people had not always been assessed and managed appropriately.

Staff did not always adhere to infection control procedures to help prevent the spread of infection to others.

Most aspects of medicines management and administration were undertaken safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff employed by the home had access to training and regular supervision. Agency staff used in 2017 had received no induction to the home.

The home complied with most aspects of the Mental Capacity Act 2005. The acting manager had sought evidence of Lasting Power of Attorney from relatives.

Most feedback about the food and drinks at the home was positive.

People had access to a range of healthcare professionals to support their wider health needs.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff employed by the home promoted people's privacy and dignity. We observed positive interactions between staff and people.

Care staff could describe people's likes, dislikes and preferences, and knew them well as individuals.

Care staff could describe what good end of life care should entail. End of life care had been discussed at a residents' and relatives' meeting in 2017.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most people received person-centred care; however, care plans were not all up to date and reflective of people's current needs.

People's access to meaningful activities was limited. This was a concern raised at the last inspection.

Complaints made about the home had been managed appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

We found continuous and new breaches of regulation which meant the provider had failed to make improvements required from the last inspection.

Audits in place at the home had identified the concerns we raised at this inspection; measures put in place to address them had yet to take effect.

People, their relatives and staff had opportunities to feedback about the service and become involved in quality improvement.

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 18, 20 and 21 July 2017. The first day was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience on the first day of inspection, two adult social care inspectors on second day of inspection, and one adult social care inspector on the final day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had been a user of healthcare services for many years and had supported adult social care inspectors on numerous other inspections.

The provider had previously been asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask for this to be updated prior to this inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. During the inspection we spoke with a healthcare professional and a vicar, who were visiting the home. After the inspection we spoke to two other healthcare professionals who visited the home to support people there.

As part of the inspection we spoke with four people who used the service, eight people's relatives, eight members of care staff (three care home advanced practitioners, two care workers and three nurses), the registered manager, the acting manager, the regional manager and a resident experience care specialist for the provider. We also spoke with a cook and an activity coordinator.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we looked at four people's care files in detail and selected care plans from 10 other people's records. We also inspected three staff members' recruitment documents, staff supervision and training records, five people's medicines administration records, accident and incident records, and various policies and procedures related to the running of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at Southfield Court. One person said, "Yes, I am safe here", and a second commented, "I feel safe here. You can talk to anyone." Relatives also thought their family members were safe at the home; one relative told us, "The care is safe and well-delivered."

Care workers we spoke with could describe the different forms of abuse and said they would report any concerns appropriately in order to keep people safe.

At the last inspection in December 2016 we identified a continuous breach of the regulation relating to staffing as sufficient staff were not deployed to meet people's needs. We issued a warning notice and asked the provider to become compliant with the regulation by 03 March 2017.

We asked people and their relatives if they thought there were enough staff on duty to meet people's needs and feedback was mixed. One person said, "I think there are enough staff", a second told us, "More often than not there are enough. Sometimes there are a few strange faces", and a third replied, "You only wait a couple of minutes."

Comments from relatives included, "They bring agency ones (staff) in to keep the numbers up", "The weekends seem to be when they are often low", "It's obviously short-staffed", "The levels have generally improved over the last couple of weeks", "The numbers (of staff) have gone up as they have taken more (people) in", "You can never find anybody when you want them, but there are plenty other times", "The number is never consistent, the other day there were only three (on that floor)", and, "Usually not enough (staff) to keep an eye on the communal spaces."

Between April and May 2017 Southfield Court admitted 17 people from another home which was closing; admissions were staggered with the aim of helping people to adjust and staff to get to know people. Rotas showed staffing levels increased as people were admitted, however, during this period the Care Quality Commission (CQC) received information of concern about staffing levels, and statutory notifications made by the home for incidences of abuse between people at the home increased markedly. This indicated staffing levels were not sufficient during the period of increased admissions as people and staff adjusted.

Feedback from care staff about staffing levels at the time of this inspection was largely positive. Most we spoke with told us there had been issues during the period of admissions to the home in April and May 2017, but staffing levels had since increased such that they were managing, but still busy. One member of care staff told us, "We work under pressure to get things done if we're short-staffed." We also asked a healthcare professional who visited the home if they thought there were sufficient staff to meet people's needs; they replied, "No, I don't think so, especially on the top floor. And I never see any activities either."

At this inspection the acting manager and regional manager showed us the dependency tool used to calculate appropriate staffing levels. We sampled five weeks' of rotas from the end of March 2017 to the time of this inspection in July 2017 and compared them to the required staffing levels generated by the

dependency tool. We found there had been some weeks where shifts had been short-staffed according to the dependency tool; for example, according to the tool there should have been ten care workers deployed each morning in the home during the week commencing 05 June 2017, whereas on five mornings there were either eight or nine staff deployed. However, rotas for the week prior to this inspection showed the home had been staffed with care workers in excess of the dependency tool.

We made observations of staffing levels during this inspection, which included the Short Observational Framework for Inspections (SOFI). This is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We saw most people's care needs were met and call buzzers were answered in a timely way, although staff were very busy, particularly in the mornings and at mealtimes. We observed people sitting in communal areas for long periods of time with staff just popping in and out occasionally. Throughout the inspection we observed people walking up and down corridors on the first floor with little interaction with staff other than passing greetings or brief enquiries about their well-being.

Feedback from people, relatives and staff, plus our observations, and records inspected evidenced there were insufficient staff deployed to meet people's needs at all times. This was a continuous breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the inspection the regional manager told us they felt the issue with staffing was one of deployment rather than low numbers. The acting manager explained different ways of deployment at busy times had been trialled but had not worked well. The management team said they would find a better way of organising staff to ensure people's needs could be met more effectively.

Most people and their relatives told us they thought the home was clean. Comments included, "Yes, it's clean", "It's clean enough", "The hygiene is good. I have only noticed smells the odd time", and, "It's not dirty but it is quite often smelly."

At the last inspection in December 2016 we noted an odour in the entrance foyer to the home, and emanating from a sluice room on a lower floor corridor. At this inspection we noted occasional pockets of odour across the home, particularly in the morning when people were getting up, and after people had received personal care. These odours did dissipate shortly afterwards and were not a persistent problem.

During the inspection we were made aware by a relative that staff had been informed the soap in a person's ensuite bathroom had run out two days earlier, and had only just been replaced. The person required support from with all aspects of their personal care and been diagnosed with a potentially communicable infection. This meant care staff supporting the person had not washed their hands on entering and leaving the room and after providing personal care for two nights and one day, thereby placing the person and other people in the home at risk of infection.

This was a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most risks to people had been assessed with control measures put in place to manage risks identified. Risks assessments in people's care files included those for choking, weight-loss, skin integrity and mobility. However, we identified concerns with the way some risk had been managed. For example, the care plans of people at risk of pressure ulcers who used air mattresses to help reduce their risk did not include the correct setting for the mattress. Three staff we spoke with did not know what the correct settings should be. We saw one mattress which was supposed to be adjusted according to the person's body weight was set at 180KG,

when they weighed less than 60KG; it was therefore far too firm. Records showed there were no people at the home who had pressure ulcers and all care plans were updated with the correct mattress setting by the second day of this inspection, so there was no impact on people. However, this meant risk to people was not always managed appropriately.

The admission of 17 people to Southfield Court during April and May 2017 had resulted in an increased number of incidents of physical abuse between people living with dementia. Healthcare professionals visiting the home had shared concerns with the Care Quality Commission about people going into the rooms of others without their permission. As a result, two people were supported on a one-to-one basis during the day and various door and sensor mat alarm systems had been deployed to help keep people safe. We found these measures were not always effective. For example, during the inspection we triggered two door alarms and no staff attended because they could not hear them. We also found two of the door sensors in place worked intermittently when triggered. During the inspection a relative raised concerns that a person was in their family member's room and would not leave; staff acted quickly but both the relative and their family member were distressed by the incident. We observed another person going into the room of a person in bed; they were also seen to climb over a seated person in a lounge area on two occasions when staff were not present. The acting manager told us the alarms in place were not fit for purpose and that a review would be undertaken as soon as possible to improve people's safety.

We saw in the behavioural needs care plan of one person who experienced behaviours which may challenge others a requirement for staff to complete 'distressed reaction forms.' A review by a community psychiatric nurse in May 2017 had also advised staff to complete antecedent, behaviour, consequence (ABC) forms after each episode of behaviours that challenge. Distressed behaviour and ABC forms are used to log episodes of challenging behaviour with the aim of identifying triggers and effective de-escalation techniques to reduce the incidences of behaviours in future. We saw there were three incidences of challenging behaviour towards other people and staff described in the person's daily notes in the two weeks prior to this inspection but no distressed reaction or ABC charts had been completed. In fact there were no distressed reaction or ABC charts on file for this person at all and they had experienced other episodes of behaviours that challenge since the 17 people moved to Southfield Court from the home that closed in April and May 2017. We also noted their behaviours care plan described triggers for behaviours but no distraction or de-escalation techniques to help staff support the person more effectively.

These concerns constituted a breach of Regulation 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as measures in place to reduce people's risk of abuse were not always effective.

The deputy manager told us the issue of staff not completing distressed reaction forms had already been raised and was being managed by disciplinary action. They said, "We've got a culture of 'it's an expected behaviour' – it's normal (for that person)", and acknowledged this was not correct. The provider was developing training sessions for care staff on supporting people with behaviours which may challenge others and the completion of distressed reaction forms to be rolled out during the month following this inspection.

As part of this inspection we checked the management and administration of medicines. The home had an effective system in place for the ordering, storing and returning of medicines. Most people's medicines were supplied by the pharmacy in blister packs, although some were in boxes and bottles. We observed a medicines round on the ground floor of the home and inspected the stock levels and storage of medicines on the first floor.

Two nurses we spoke with could demonstrate their knowledge of medicines administered to people for dementia.

We observed a nurse and a CHAP were administering medicines together as the nurse was new and did not know people well yet. We saw they asked the CHAP about each person and how they liked to take their medicines before going to administer medicines, and recorded them as taken on people's medicines administration chart (MAR) afterwards.

Medicines were stored in trolleys which were locked to the wall of the locked clinic room between rounds. We checked the stock levels of three medicines prescribed to people 'when required' and three controlled drugs, and they tallied with stock records. A sample of people's MARs we checked had no gaps, which evidenced people had received their medicines as prescribed. This included most people's topical creams, whose application was recorded on separate topical MARs by the care workers who applied them.

We did, however, identify some issues with medicines management during the inspection. For example, we identified a small number of 'when required' medicines that did not have medicine care plans to advise staff on how and when to administer them. One person's topical MAR sheets were in their room rather than in a folder with other people's and had not been completed, although we saw their creams had been used. A third person's allergy status on their MAR conflicted with what was on their care plan. We fed back these issues to the acting manager who said they would rectify them immediately. A medicine audit undertaken during the week prior to this inspection had identified the issue with missing 'when required' medicine care plans so this work was already underway. This meant most aspects of medicines management were done safely.

We checked the personnel records of three members of staff recently recruited to the home. All the relevant documentation to evidence safe recruitment of appropriately qualified staff was evidenced, including a check with the Disclosure and Barring Service (DBS), except for one staff member who only had one previous employer reference. This was sourced by the end of the day and included no concerns about the suitability of the staff member. As noted previously in this report, the home had relied heavily on agency staff for several weeks prior to this inspection, so we checked the records of agency staff used. Each had a personal profile which listed their training and professional qualifications, if relevant. This meant only suitably qualified and vetted staff were deployed at the home.

At the last inspection in December 2016 we noted some people wearing only socks on their feet, and not slippers or shoes. Since then we received feedback from other healthcare professionals who have visited the home and raised the same concern. At this inspection we saw people on the first floor of the home regularly mobilising without footwear. Most of the time care staff noted the lack of footwear, went to find it, and helped the people to put their footwear back on. However, on a few occasions we had to ask care staff where people's footwear was; they told us the people took off their shoes or slippers and walked away without them. We saw this was documented in the care plans of people who did this. The regional manager said they would consider 'slipper socks' with extra grip for those people most often seen mobilising without footwear.

Records showed the appropriate checks had been made on the building, its utilities, facilities and equipment. Fire drills were undertaken regularly and people each had a personal emergency evacuation plan, which included information for those supporting people to exit the building in an emergency.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought the staff at Southfield Court were well trained. One person said, "Yes, I think they are well trained", and a second told us, "They know what they are doing." Relatives' comments included, "They (the staff) have gone through a lot of training since we've been here", "I believe so (that staff are well trained). [My relative] is always happy with the staff", and, "They know what they are doing and do it well."

Records showed staff employed by the home received the induction, training and supervision they required to provide effective care and treatment. Staff employed new to health and social care had been enrolled on the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care.

The majority of training courses staff completed were online, although some were face to face. Records showed most staff were up to date with courses such as moving and handling, dementia awareness, fire safety, pressure ulcer care, safeguarding and first aid. Nursing staff and care home advanced practitioners had been assessed for their competency to administer medicines, and nurses had also received training in catheter care and enteral feeding (supporting people who receive food via a stomach tube).

Records showed care staff had access to regular supervision which was supportive and focused on their well-being and personal and professional development. Issues identified during audits or inspections were discussed and any training needs identified. This meant staff received the training and support they needed to meet people's needs.

As discussed earlier in this report, due to staffing issues at the home there had been a heavy reliance on agency nurses and care workers in the weeks preceding this inspection. According to the registered provider's policy each agency staff member should receive an induction when starting to work at the home. Records showed none of the agency staff used by the home in 2017 had received an induction. This issue had already been identified by the acting manager; they had spoken with the staff responsible for providing agency staff inductions. No new agency staff had been used since concerns had been raised, but the acting manager said they would complete checks whenever agency staff were used in future to ensure inductions were done.

The lack of induction for agency staff constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection in December 2016 we noted a person's care file did not contain evidence of their relative's Lasting Power of Attorney (LPA) to manage their property and finances. At this inspection records showed the acting manager had sent out letters to relatives to ask for evidence of LPA for property and finances and/or people's health and welfare, if they had it. We saw one person's care file did now include evidence a relative had Enduring Power of Attorney (this has since been superseded by LPA in law). The

acting manager said LPA and best interest decision involvement had also been discussed with relatives at one of their regular meetings to raise awareness. This meant the home had sought to identify the extent to which people's relatives could legally be involved in decision-making on their behalf.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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. Care files we sampled showed people who needed DoLS had them in place and none of the authorisations we saw had conditions.

All but one care file we sampled contained evidence people's capacity to consent to various aspects of their care and treatment had been assessed, with best interest decisions made, in line with the requirements of the MCA, if required. One person's care file contained an assessment of their capacity to consent to a decision for staff not to administer cardiopulmonary resuscitation if they had a cardiac arrest. A best interest decision had also been made, but we saw it was signed by home staff only and had not involved a member of the person's family or an advocate. Consent forms for this person to take their photograph and share their medical records with other healthcare professionals had also been signed by staff from the home. Records did not show how these decisions had been made or whether they were in the person's best interest. This meant not all decisions had been made according to the Mental Capacity Act code of practice.

We noted the home did not routinely undertake capacity assessments and best interest decisions for the administration of medicines to people thought to have problems making decisions. The regional manager emphasised the home always undertook such assessments for people receiving their medicines covertly, which we saw, but did not do them for general medicines administration. The regional manager said they would discuss this issue with the provider's advisors for dementia care and treatment.

Most of the feedback people gave us about the food and drinks served at Southfield Court was positive. Comments included, "The meals are all right. Well-cooked and good choices", "There are two choices and they will make you a sandwich if you want something else", "You can have drinks and things if you want", and, "There are cups of tea galore." However, one person told us, "The meals are poor, dished out poorly, thrown on a plate. All plastic plates." Relatives were mostly positive about the food, telling us, "The meals are good. [My relative] has put weight on since being here", "The meals are good. Good choices and well-cooked", and, "Some meals are all right, some I don't think much of."

We spoke with the chef who told us the home had a four-weekly menu and two choices at lunch and tea every day. The chef could also describe how to modify foods for people on special diets, such as those who needed fortified foods, people with diabetes and people with swallowing problems. Records in the kitchen showed all the correct checks had been made on foods prior to serving and on food storage equipment.

Care staff showed us information about people's special dietary needs was kept in the kitchen serving areas on each floor. Records were kept of the intake of diet and fluids for people at risk of losing weight; a healthcare professional who visited the home told us, "The food charts are fantastic." During the inspection

we saw people receiving support to eat and drink at mealtimes and between meals, when they were offered drinks and snacks. All support we observed was provided in a respectful way, however, we saw one person who was supported to drink but not told what the drink was, a second person who was asked if they wanted 'fruit' and then supported to eat a pudding of some kind but not told what it was, and a third person received a pudding without being given any choices first. This meant communication between staff and people at mealtimes could be improved.

A healthcare professional we spoke with as part of this inspection told us they had advised the home to ensure the second choice at teatime for people who needed a pureed diet was more substantial than soup. They said since they had provided the advice it had been followed by cooks at the home. However, on the second day of this inspection we noted at teatime people who needed a pureed diet could choose from burger, mash and beans, or soup. When we queried this with the regional manager they were aware of the advice provided and surprised two substantial choices were not offered. They said they would resolve the issue, and described other measures the home was introducing for people on pureed diets, including sandwiches made from pureed bread and fillings made to look like sandwiches. We will check this at the next inspection.

People's relatives told us referrals and appointments with healthcare professionals were arranged when they were needed. Comments included, "There is good access. SALT (speech and language therapist), dietician and physio (physiotherapist)", "We are told about referrals, there is reasonable access", and, "[My relative] has been referred several times."

Records we sampled evidenced people had seen a range of healthcare professionals in order to meet their wider heath needs. Healthcare professionals we spoke with gave us positive feedback about their involvement with the home and its staff. One told us, "The staff are really cooperative and caring, and helpful", a second told us, "I always find them (the staff) to be helpful", and a third commented, "They do ring me and have rung me if they've had any problems." This meant the home supported people to maintain their wider health and made appropriate referrals.

The home had been modified to aid navigation by people living with dementia. Wall colours were plain and light with contrasting handrails to make them easier to see. Floor colour was muted and with minimal patterning to reduce visual confusion when walking. Rooms, such as bathrooms, dining rooms and toilets had word and picture signage and lighting was bright. This meant good practice in dementia care had been used in the design and décor of the home.

Good

Is the service caring?

Our findings

People told us the permanent staff at the home were kind and caring; some feedback about agency staff was less positive. One person said, "They (the staff) are caring and respectful", a second person told us, "The normal ones (permanent staff) are kind and caring. I don't know how they do their job", and a third person commented, "Agency ones (staff) can be a bit unhelpful and don't do the job written down." Feedback from relatives about the staff was all positive. Comments included, "They are kind and compassionate. They (people) are treated properly, with respect", "All are lovely; excellent", and "They treat [my relative] nicely."

Throughout the inspection we observed warm and respectful interactions between care staff and people, with laughter and banter at times. People's relatives told us they were always made to feel welcome. We saw care staff were polite towards relatives and had clearly formed friendly relationships with regular visitors to the home.

People and their relatives liked the atmosphere at Southfield Court. One person told us, "It's a friendly, caring place", and a second said, "It's a nice place. The people who run it are nice." Comments from relatives included, "The atmosphere is good", "Generally very good, they make an effort", and, "I would recommend it. It's a testament to the home that [my relative] is happy here."

People told us they could make choices about the care they received and when they received it. In terms of baths and showers, one person told us, "I should imagine I could have one (a shower) if I wanted to", and a second person said, "I just ask to have one (bath or shower) on the day and they say yes and tell me what time." People also said they could decide if and when they wanted to get up and go to bed. One person told us, "I choose to go to bed when I want." People said staff asked for their consent before providing support; one person commented, "They explain things and ask for consent." This meant people could exercise choice over the support they received.

Staff we spoke with could describe people well as individuals, and demonstrate knowledge of people's likes, dislikes and preferences. This included the 17 people who had moved from the home which was closing in April and May 2017. People could choose to have information and photographs from their personal history displayed outside their rooms. Care staff could describe how they supported people to remain independent and we saw this was reflected in people's care plans. For example, in one person's continence care plan it said, '[Name] would like the staff to promote as much independence as possible as it makes [them] feel [they are] doing [their] best.' We observed people being encouraged to eat and drink independently by staff during the inspection. A relative said of their family member, "They try and push [my relative] to do things on [their] good days." This meant people were supported to remain independent by staff who knew them well.

Relatives told us care staff respected people's privacy and dignity. One relative said, "The door is shut and the curtains drawn every time (during personal care)." Care workers gave us examples of how they supported people to maintain their dignity, for example, by closing doors and curtains and keeping people covered as much as possible when providing personal care. People were also offered aprons at mealtimes to protect their clothing and received prompt support with their continence when it was required. This

meant care staff were respectful of people's privacy and dignity.

We asked people and their relatives how they had been involved in planning the care people needed. One person said, "I'm not really involved in my care plan", whereas people's relatives told us, "Yes, I am involved in the care plan. I am part of the review", "I am involved on a daily basis, they respond to anything", "I don't get involved. I have confidence the girls (care staff) know what they are doing", and, "I could be (involved in my relative's care plan) if I wanted to. I have read it a while ago."

When we read people's care files we found it was not clear how people and their relatives had been involved in the care planning process; we raised this with the acting manager. They explained how care staff went to speak with people and their relatives to find out if any changes or updates were required, but agreed this consultation was not recorded in people's care plans. The acting manager said they would ensure better recording of discussions between people and their relatives about people's care needs would be added to people's care plans to show how people had been involved. We will check this at the next inspection.

Both the acting manager and registered manager could explain the process for referring people to advocacy services and gave appropriate examples of when they would consider a referral was required. Records showed people at the home had been referred to advocacy services when they needed help with decision-making. This meant people had access to independent support with decision-making when they needed it.

We noted people's DNACPR forms, if they had them, were located at the front of their care files. The DNACPR or 'do not attempt cardiopulmonary resuscitation' decisions had people's correct name and address details on. People's DNACPR forms were also referenced in their end of life care plans, along with any other future wishes which had been expressed. One relative told us, "End of life care (for my family member) has been discussed and planned", and we saw a recent compliment from the family of a person supported with end of life care at Southfield Court. The registered manager told us end of life care had been discussed at a residents' and relatives' meeting in 2017, and a professional from the local community healthcare team had attended to give advice and information. She said relatives had taken leaflets on the subject and asked questions. This meant the home actively discussed end of life care with people and their relatives in order to plan for the future.

We asked care staff to describe the important aspects of good end of life care. One member of care staff told us, "We keep them comfortable and settled. Keep family informed. They may need anticipatory drugs to be pain-free; and mouth care", and a second said, "It means comfort, hydration, looking after them well. Hygiene is important, oral care, looking after their continence." This meant care staff knew how to meet people's care needs at the end of life.

Requires Improvement

Is the service responsive?

Our findings

People told us they had never made a complaint about the service they received at Southfield Court. One person said, "No, I haven't complained. To be honest if I wanted something they are there to do it", and a second person told us, "No, I haven't got anything to complain about." Two relatives we spoke with had never complained, but another one had. They told us, "I have made a formal one (complaint). I sent a letter to the manager and got a good response."

At the last inspection in December 2016 we found a continuing breach of the regulations relating to person-centred care and good governance as people's care plans were not always updated when their needs changed, and some staff did not know about these changes. We issued a warning notice and asked the registered provider to become compliant with the regulation by 03 March 2017.

At this inspection we sampled care plans and found most were detailed, person-centred and up to date. People had care plans for a range of aspects, including mobility, nutrition, skin integrity and human behaviour (which included behaviours that may challenge others). The reasons any people were nursed in bed were documented in their care plans. Some other care plans we saw had been updated when people's needs had changed, for example, when a person had been reviewed by a visiting healthcare professional.

However, we did find care plans which did not reflect people's current needs. We also saw 'At a glance' care summaries at the front of people's care files, for use by agency staff, at times contradicted what was in people's main care plans. The 'At a glance' care summaries were undated, so it was not possible to tell when they had last been updated. It was also difficult to identify some people's current needs from their care plans, as when their needs changed this had been added on to the bottom of their care plan, rather than the plan being rewritten. This meant the first information read was no longer relevant; it was an issue we raised at our last inspection in December 2016.

Information in the skin integrity care plans, mobility care plans and 'At a glance' care summaries for three people was contradictory in terms of the support each person needed to reposition and how frequently this should be. Daily records for the two days prior to this inspection for each person showed they were assisted to reposition regularly and had no pressure ulcers, suggesting this was a recording issue.

One of these people's nutrition care plan started with an entry from July 2015 which stated the person could eat and drink 'normal' consistency foods and fluids independently. A later entry from January 2017 stated the person required a pureed diet and was to be offered dietary supplements due to weight loss. A further entry from May 2017 stated the person needed a fortified diet with extra snacks. During the inspection we observed the person drinking independently but being assisted to eat pureed food by a care worker. The person's needs were described over four pages of handwritten entries, which made it difficult to determine exactly what support they needed.

Another of these three people's records showed they had been reviewed by external healthcare professionals who had provided advice on 23 June 2017 about the person's medicines and a specific aspect

of their personal care. At the time of this inspection on 18 July 2017, the person's care plans had not been updated to include this information, although a care worker could describe the support the person needed with personal care, and medicines had not been given contrary to the advice provided.

The registered manager told us a recent audit by the provider of 15 care plans had found issues with all 15; she assured us the update and review of care plans was already part of an action plan to improve the service.

We found people were receiving care that was person-centred, however their care plans were not an accurate and contemporaneous record of their needs. This was a continuous breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The transfer of 17 people from a home that was closing to Southfield Court in April and May 2017 had been discussed and agreed with the local authority and clinical commissioning group. Each person was assessed prior to their move and staff from the closing home, including the registered manager, came with people when they moved and worked shifts at Southfield Court to help settle people in and to familiarise staff with people's needs. People that moved to the home had the same format of care documentation because the other home was run by the same provider. The care plans of these people had been reviewed when they moved in, and we saw most of these were up to date. During this inspection we saw people who had moved from the other home now appeared settled and familiar with their new surroundings, and care staff could describe their individual care needs and preferences.

Feedback from people and their relatives about the provision of activities at the home was largely positive. One person told us, "The girls in red (activities coordinators) come in and talk to me", and a second person said, "Sometimes we play games or we watch telly. There are some good things on." Comments from relatives included, "[My relative] takes part in painting, making cards and baking", "The activity girl visits in the room; hand massages, painting. There is enough to do", "There is not really enough to do", and, "They offer the chance to join in but [my relative] likes [their] own company." Relatives also told us they were welcome to visit at any time.

At the last inspection in December 2016 we found some people's access to meaningful activity was limited. One activity coordinator worked 22 hours per week and another 16.5 hour a week post was vacant.

At this inspection we found the situation to be largely the same. One activities coordinator worked 16.5 hours over three days a week (Mondays, Wednesdays and Thursdays); another full time activities coordinator was on long term sick leave and no measures had been put in place to cover their hours. As a result, because the staff were busy meeting people's care needs, we observed very few activities during the inspection. On the first day a vicar came to the home to conduct a church service. We saw people were asked if they wanted to attend. The same day we sat for two hours in a communal room with one other person, where two other people regularly mobilised in and out. Various staff members popped in and out, but no one sat down to engage people in conversation or activities. On the last day of this inspection we sat for 50 minutes in a communal area with five people before lunch. Two care workers popped in and out, and both sat and spoke with one person for a few minutes, but there was no interaction with or stimulation of the other people.

We looked at people's activity records to see what they had been doing. One person's records had six entries for the previous month, five of which were either a chat with staff or a relative visiting. The sixth was 'a soak in the bath.' A second person had seven entries in their activity records for the month prior to this inspection. One of these was being 'greeted by staff', and five were activities undertaken with the activities

coordinator. A third person's activities records had nine entries for the month prior to this inspection. These included a visit by a relative, a bubble bath and 'socialising with staff.' This meant records showed people's access to activities had been limited.

The weather was pleasant and summery the week of this inspection, yet we noted none of the people went outside to use the garden. On examination, we found the garden to be overgrown and unsuitable for people's use. One relative commented, "I would prefer a better garden; that's my only criticism." The acting manager said there had been no gardener employed for several months and they had experienced problems getting a contractor in to make improvements. This meant people remained indoors on nice days because they could not access the garden.

People lacked a sufficient provision of meaningful activities. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the regional manager said they would seek a temporary replacement for the activities coordinator who was on sick leave.

Records showed complaints made by people and relatives about the home or the care and treatment received had been investigated and appropriate responses provided in accordance with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

We asked people and their relatives if the home was well-managed. Most feedback was positive. Comments included, "Yes, it's well-managed", "Yes, I can't find fault", "Yes I do. The new manager is working hard", "It's better now, now that the old manager is back [from extended leave]", "The management could be better, (it is) not consistent", and, "So far it seems well run from what I've seen."

At the last inspection in December 2016 we found there had been an improvement in governance at the home from the previous inspection in March 2016; however, issues were still identified which constituted a continuous breach of the regulation relating to good governance. These included the quality and relevance of people's care plans and the efficacy of audit and monitoring at the home to drive improvement. We asked the provider to send us an action plan telling us how they would become compliant with the regulation.

The home had a registered manager. She had been on extended leave since November 2016 and had re-commenced at the home on a phased return during the week prior to this inspection and would be working four days a week by the middle of August 2017. In her absence the deputy manager had become acting manager, with support from various staff from the provider, including the regional manager and a resident experience care specialist.

As discussed previously in this report, at this inspection we identified a further continuous breach of the regulation relating to good governance as some care plans were still not an accurate and contemporaneous record of people's needs.

Records showed various aspects of the service were monitored for quality and safety on a monthly basis, including mattress integrity and cleanliness, bedrails, health and safety, infection control, accidents and incidents, and medicines. Data relating to people was also compiled by the home manager on a monthly basis and reported to the regional manager, a so-called 'vulnerable adults list.' We saw this consisted of people who had lost weight, people at high risk of falls or choking, any issues with skin integrity, and people with catheters. The registered manager told us the regional manager analysed the information and gave her additional actions or asked for more information, to ensure the appropriate action had been taken.

The regional manager also conducted their own audits at the home on a monthly basis. Records showed this had included talking to staff to gauge their knowledge of policies and procedures, reviewing care plans, checking the home's cleanliness, evaluating the quality of daily records, and checking recruitment records. Their audits had highlighted issues with staff hand hygiene and staff not completing distressed reaction forms when people experienced behaviours which may challenge others. Members of the provider's resident experience team had also been conducting audits at the home in order to support the acting manager. We saw multiple concerns had been highlighted which mirrored the findings of this inspection. For example, a lack of activities, no soap and limited personal protective equipment in some bathrooms, a lack of medicines care plans for some people's 'when required' medicines, and care plans not being updated. This meant audit at the home had been effective in identifying issues and concerns; however, action to resolve concerns had yet to be implemented with effect.

Some measures had been put in place to try and resolve issues at the home. For example, we noted two of the care files we inspected had not been reviewed and updated on a monthly basis in 2017 in line with the provider's policy. The regional manager told us this had already been identified by audit and in response the home had started a 'resident of the day' system on 01 July 2017, whereby the care plans of one person from each floor were updated on the same day each month. A care worker told us the new system was working well, and each day the acting manager checked the care files due for update the day before to make sure they had been done. Audits by the provider had also highlighted gaps in people's daily records during April and May 2017 when 17 people had moved from another home which had closed. In response, since the end of June 2017 the acting manager had been conducting a daily audit of each person's daily records, for example food and fluid records, repositioning charts, and records of the regular checks made on people's well-being. This was fed back to the provider with the purpose of ensuring people's needs were being met by staff. Shortly before the inspection the provider had also written to all staff to express concerns about the standard of record-keeping at the home. The regional manager told us if it did not improve they would use the disciplinary process. This meant the provider was taking steps to improve record-keeping at the home.

We discussed the challenges the home faced with the registered manager. She said the admission of 17 people from a home which was closing in April and May 2017 had resulted in a turnover of staff, new people had needed additional support to adjust to their new home, there had been changes in management, and staff who had been used to working at a low home occupancy level needed to adjust to a higher occupancy rate once again. The registered manager said she was committed to improving the home now that she was back from a period of extended leave and stated, "It's going to be a team effort to turn it around." The regional manager said of the high number of admissions in April and May 2017 from the home that closed, "With hindsight we'd maybe have done it differently. Gone at a slower pace."

At the last inspection we found the home was on a trajectory of improvement, although warning notices were served for breaches of regulation relating to staffing levels and the provision of person-centred care. A requirement notice was also served for a breach of the regulation relating to good governance because people's care plans were not always up to date and not all concerns raised at the last inspection had been addressed. At this inspection we identified continuous breaches of the regulations relating to staffing and good governance for the same concerns. This meant the provider's leadership and governance at the home had not been sufficient to ensure the required improvements were made.

This was a continuous breach of Regulation 17 (1) and (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were various ways people, their relatives and staff could feedback about the home. Residents and relatives had regular meetings to discuss the home, which were organised and chaired by relatives. Minutes for meetings held since the last inspection in December 2016 showed topics such as the summer fayre, Lasting Power of Attorney, the plans for the intake of people from the home which closed, and the results of various inspections at the home had been discussed. An annual survey was coordinated by the provider and an electronic device was located in the entrance foyer to the home, where relatives and staff could give feedback. Comments made on the device were reviewed by the provider and a 'You said, we did' board was located in the home's foyer to show how feedback had been acted upon. We asked about the location of the 'You said, we did' board in the foyer which was in an area people could not access freely. The regional manager said another board would be installed in one of the home's communal areas. This meant people and relatives were given opportunities to feedback about the service.

Staff attended a variety of meetings at the home. General staff meetings were held regularly and a range of issues relating to good practice, staff morale and changes at the home had been discussed. Minutes showed

negative staff feedback via the electronic device about whether they would recommend the home had been discussed at meetings in January and April 2017. The acting manager had asked for reasons for this and offered to speak to staff in confidence if they preferred. Care staff feedback about staff meetings was positive. One care worker told us, "We can share opinions and get asked for ideas." Other meetings held at the home were those for nursing staff, as well meetings of a clinical governance committee, and health and safety committee, which had representatives from all staff levels. This meant staff at the home were given opportunities to feedback about the service and become involved in quality improvement.

Registered providers have a responsibility to report certain incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We checked the records for these types of incidents and found they had all been reported appropriately. Registered providers also have a legal duty under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw ratings from the last inspection were clearly displayed in the foyer of the home and on the registered provider's website.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's access to meaningful activity was limited. This was a concern raised at the last inspection. Regulation 9 (1)

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 Staff did not adhere to infection control good practice at all times. Regulation 12 (1) and (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Measures in place to reduce people's risk of abuse and the incidence of people's behaviours that may challenge others were not always effective. Regulation 13 (1) and (2)

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 17 HSCA RA Regulations 2014 Good governance People's care plans were not always an accurate and contemporaneous record of their care and support needs. Regulation 17 (1) and (2) (c) Breaches of regulation identified at the last inspection had not been addressed and new breaches of regulation were found at this inspection. Regulation 17 (1) and (2) (a) (b) (c) (f)

The enforcement action we took:

We imposed a condition on the registered provider's registration for this home.

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 There were insufficient staff deployed to meet people's needs at all times. This was a continuous breach from the last inspection. Regulation 18 (1) Agency staff used at the home in 2017 had not received an appropriate induction to the home. Regulation 18 (1)

The enforcement action we took:

We imposed a condition on the registered provider's registration for this home.