Thanweer Care Limited

Southlands Court Residential Home

Inspection report

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26 September 2017

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 18, 20 and 26 September 2017. Southlands Court provides accommodation and personal care for up to 25 people. Any nursing needs are met through community nursing services. There were 24 people living at the home at the time of the inspection. The service had a new provider who had registered the service with the Care Quality Commission (CQC) in October 2016. This was the provider's first inspection of the service.

The service is required to have a registered manager as a condition of registration. Southlands Court did not have a registered manager at the time of inspection; the previous registered manager last worked at the home in June 2017 and had since left the employment of the provider. The assistant manager had taken up the position of manager in August 2017. They have submitted an application to CQC to become the registered manager at the service. 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.

People's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times to meet their needs. The CQC wrote a letter to the provider on 21 September 2017 because of the inadequate staffing levels at the service. We were so concerned about some of the findings during the first two days of our inspection visits that, on 21 September 2017, we wrote to the provider setting out our concerns. We asked them how they planned to ensure people living at Southlands Court were being kept safe. The provider's response acknowledged the concerns raised and gave a commitment to addressing them. They said action was being in some areas. The provider gave CQC assurances in their response that they would increase the staffing at the service. On the third day of our inspection the provider had increased the staffing levels at the home. However they had not undertaken any assessment to demonstrate how the new staff levels were adequate to meet people's needs.

However, CQC did not feel the response gave adequate assurance to improve the safety systems. The CQC therefore used urgent enforcement powers to impose conditions on the provider's registration under section 31 of the Health and Social Care Act 2008 to set out what actions we required the provider to take and the timescales required.

On the 28 September 2017 we issued an urgent Notice of Decision to impose conditions on the provider's registration. We told the provider that they must not admit people to the service without the written permission of CQC. They must have a tool in place to determine the number of staff and range of skills required in order to meet the needs of the people using the service. We also said they must complete this assessment and keep it under regular review and send CQC the assessed staffing levels identified each week.

Since CQC issued the conditions on the provider's registration the provider has undertaken the required

audits and risk assessments and has submitted the actions they have taken to CQC as required. We have since the inspection spoken with the provider and manager and received further assurances that audits have been completed and systems have been put into place to undertake regular monitoring in order to mitigate further risks.

People were not protected from unsafe and unsuitable premises. The provider's quality assurance systems did not effectively assess and monitor the quality and safety of the service. There were no systems to monitor fire safety and health and safety. The provider had not completed any environmental risk assessments or monitoring checks to ensure the environment was safe. In particular, we highlighted scald risks related to the hot water supply and the possible risk to people of the large pond in the courtyard accessible to people which had not been assessed. No monitoring checks had been undertaken in relation to bedrails and beds to ensure they were safe. No checks were undertaken to ensure window restrictors were in place and effective to keep people safe from falling out of windows.

There was no system in place to ensure the service was meeting fire regulations. These included staff training, fire drills and environmental checks. Individual plans to ensure people were kept safe in the event of a fire had not been drawn up.

There was not a system in place to protect people from the risks associated with their care needs. There were no risk assessments regarding people's nutritional needs, skin integrity, falls risk or manual handling risks. Therefore it was not possible to provide guidance and direction for staff about how to support people and ensure that care and treatment was provided in a safe way.

Staff had recorded accidents promptly in the accident books and the actions they had taken at the time. However there was no assessment or review of people's falls and accidents to monitor and mitigate future risks. Where people had had a serious injury or numerous falls these incidents had not been reviewed and analysed to look for ways to keep people safe from further harm.

People did not receive person-centred care that met their needs and reflected their choices and preferences. Care plans did not contain information about people's care needs and had not been updated to reflect people's changing needs. Some care plans had not been reviewed by staff since October 2016. People and relatives where appropriate had not been involved in reviewing care, support and treatment plans to ensure they reflected the way people preferred to receive their care. Records showed and health professionals confirmed that staff referred people to health professionals regularly and recorded their visits. However care plans were not updated to reflect their guidance. One person's care plans did not demonstrate how decisions had been made regarding the consistency of their diet and whether the speech and language team (SALT) had been involved in the decision.

People received a nutritious diet and enough to eat and drink to meet their individual needs. The manager was working with staff to make improvements to the menu and choices available for people.

Health professionals gave positive feedback about the care provided at the service, in particular the end of life care received by one person. People said they felt safe and cared for in the home. During our visits staff were kind and caring in their approach to people and treated people with dignity and respect. However they had not ensured that people's dignity was maintained at all times.

People and their families were not being given sufficient opportunities to be actively involved in developing the service. Although people could provide feedback on an ad hoc basis, there were no regular resident or family meetings and no regular surveys to ask people and visitors their views.

Activities were available for people most days. There was a staff member designated to undertake activities which included one to one activities with people in their rooms to help avoid social isolation. The manager had been working with staff to further improve the activity provision at the service. The provider had purchased a minibus which had meant people were able to go on outings.

People who lacked mental capacity to take particular decisions were not protected. The provider had not acted in accordance with the Mental Capacity Act 2005 (MCA). The provider had not ensured where someone lacked capacity to make a specific decision, a capacity assessment and a best interest assessment was carried out. Where a power of attorney (POA) was appointed for a person, there was no system to identify whether the POA was authorised for making care and treatment decisions, finances or both. Therefore staff might not be aware whether a relative had the right to make a decision on behalf of a person living in the home.

The manager and deputy manager had been working to ensure there was a safe system in place for the management and review of medicines. They had recognised there were areas for improvement and had taken action to put measures in place. The improvements included ensuring medicines were ordered in a timely manner, a stock balance maintained and audits carried out.

The staff training records did not demonstrate staff had the knowledge and skills they needed to support people's care and treatment needs. The manager had identified there were numerous gaps in staff training records. They were taking action to arrange training to ensure staff had received the provider's mandatory training.

Since they had taken over, the manager had ensured new staff being recruited had all the necessary checks made before they commenced employment. Systems were put into place during our inspection to check agency staff identification when they arrived at the home. An induction for agency staff was also introduced so they knew how to support people and what to do in an emergency.

The manager had recognised the importance of actively involving staff in developing the service. They had held staff meetings and one to one supervisions with staff and said they would be held regularly to discuss concerns and changes which were being implemented.

The policies and procedures in use at the service were ineffective because they did not reflect the current practice. There was an off the shelf template of policies and procedures which the provider and the manager said they would use to put in place accurate policies and procedures that would give staff clear guidance about the practice expected.

The complaints procedure did not guide people how to raise a concern and the process that would be undertaken. Where a complaint had been received this had not been recorded. The manager said they would put in place a complaints procedure and a system to record complaints according to the new policy when it was put into place.

The provider is required by law to send CQC notifications about important events at the service. For example, deaths, serious injuries or safeguarding concerns. We had not received notifications as required from the provider since March 2017. Since the inspection two expected death notifications have been submitted retrospectively.

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 time frame. If not enough improvement is made within this time frame 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.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, person centred care, safe care and treatment, consent, submitting notifications and good governance. You can see what action we have taken at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times.

People were not protected from unsafe and unsuitable premises. In particular, we highlighted scald risks related to the hot water supply at the home and the risks associated with the pond in the courtyard at the centre of the service.

Staff had not completed individual risk assessments for people to assess how to reduce risks as much as possible.

There were no systems or checks in place to make sure the service was meeting the fire regulations. A fire risk assessment had not been completed to identify areas of concern within the service in relation to fire risks.

People were protected by staff that were aware of the signs of abuse and would report concerns. However not all staff had received training in adult safeguarding.

People were protected by safe recruitment processes.

Improvements had been made to ensure medicines were safely managed.

Accidents and incidents were recorded in the accident book by staff and the actions taken at the time. However these were not analysed or used to reduce the likelihood of a recurrence

Is the service effective?

Requires Improvement

The service was not effective.

Staff training did not ensure staff had the knowledge and skills they needed to support people's care and treatment needs.

The provider had not ensured staff had followed the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards

(DoLS) code of practice.

Staff had received supervisions.

People received a nutritious diet and enough to eat and drink to meet their individual needs. Improvements regarding choice were being implemented by the manager.

Advice and guidance was regularly sought from relevant professionals to meet people's healthcare needs. However this was not always recorded and there were occasions when this had not been the case.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always treat people with dignity and respect when helping them with daily personal care.

Staff involved people in their care and supported them to make daily choices while they were undertaking their care.

End of life care was good at the service. However end of life care planning had not taken place so there was no assurance that people's needs were known and met.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care plans did not accurately reflect their care needs and were not updated in a timely manner to reflect people's changing needs.

People and relatives had not been involved in the development and reviews of their care plans.

Staff were quick to refer people to health professionals and recorded their visits. However care plans were not updated to reflect their guidance.

There was not an accurate complaint procedure available to guide people how to make a complaint. Where a complaint had been received this had not been recorded.

People had the opportunity to take part in activities. Where people stayed in their rooms' activity provision was provided to

ensure they were not at risk of social isolation.

Is the service well-led?

Inadequate

The service was not well led.

People were at risk because of the lack of quality monitoring arrangements at the service.

There were limited opportunities for people and their relatives to give their views about how the service was run.

Accidents and incidents were not properly analysed. There was a lack of actions to reduce incidents and to respond to risk trends identified.

The policies and procedures in place were ineffective and did not reflect the practice at the service.

Notifications had not been reported to CQC in accordance with the regulations.

Staff views were sought and taken into account in how the service was run.

Southlands Court Residential 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 checked 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 comprehensive inspection took place on 18, 20 and 26 September 2017. The first visit was unannounced and carried out by one adult social care inspector. The second visit was announced so the adult social care inspector could speak with the provider who was visiting the service on that day. The third day was unannounced and was carried out by two adult social care inspectors.

Before the inspection, the new manager on behalf of the provider completed 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 reviewed the PIR and other information we held about the home. This included notifications sent to us. A notification is information about important events which the service is required to send us by law.

We met the majority of the people who lived at the service and received feedback from five people who were able to tell us about their experiences. Several people at the home had a dementia type condition. A few people using the service were unable to provide detailed feedback about their experience of life at the home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We spoke with three visitors to ask their views about the service.

We spoke with 11 staff, including the new manager, deputy manager, senior care worker, care workers, cooks, housekeepers, an activity person and one of the providers. We also spoke with an agency care worker

who was undertaking a shift at the service. During the inspection we spoke with three visiting community nurses and a social care manager to ask their views about the service.

We reviewed information about people's care and how the service was managed. This included five people's care records and five medicine records. We reviewed records relating to the management of the service, which included staff training, staff support, three staff employment records, quality assurance audits and minutes of team meetings. After the inspection, we contacted health and social care professionals and commissioners of the service for their views. We received a response from one health and social care professional. We also contacted the local fire officer and the environmental food and safety officer to make them aware of our concerns.

Inadequate

Is the service safe?

Our findings

People were at risk of receiving inappropriate and unsafe care. The provider had not ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times. The provider did not have a system in place to assess people's dependency to determine the number of staff and range of skills required in order to meet people's needs.

People using the service and their relatives said they felt at times the staff levels at the service were too low. Comments included, "They have been very short staffed, don't get me wrong they are all lovely. The agency carer came and introduced herself. I asked did she have two pairs of hands as they do need help"; "There are not enough staff, sometimes they are running around a lot" and "Having a bath is a bit of a problem, they are very busy, there are not enough of them, I ask two days in advance. They are very good when I ask."

Staff comments included, "We need more staff on the floor. The home has changed a lot to the amount of staff, it needs to catch up, so residents don't have to be rushed"; "I think it is important we have four staff on in the morning so the senior isn't interrupted when they are doing the medication"; "We need more staff" and "The biggest issue here is the staffing and the paperwork."

The new manager had made the provider aware of their concerns in relation to the staff levels at the home. However, changes to address these concerns had not been implemented at the time of the inspection. Each morning the number of care staff on duty was a senior care worker and two care staff. They were supported by a cook and two kitchen staff; these staff supported people with their breakfast and mid-morning refreshments. The manager said that 10 people required two staff to assist them with their mobility and personal care needs. Therefore when one of these ten people required personal assistance, for example to get up, two staff performed this role. This left only the senior care worker available to support others; however the senior care worker was also responsible for medicine administration at the same time. This meant that people had long periods of time when staff were not readily available to support them. For example, on 20 September 2017, three people were left sat after breakfast at the dining room tables waiting to go to their rooms or the lounge until just before midday. One of these people said they wanted to go back to their room. During this time, no staff were observed asking people whether they wished to move. The provider wrote to us after the inspection to state that some people choose to stay in the dining room and staff may have asked their preference prior to our observation.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider had not ensured there were sufficient numbers of staff at all times to meet people's needs.

We wrote to the provider on 21 September 2017 regarding the staffing levels at the service. The provider took action and increased the care staff level by nine hours a day starting on Monday 25 September 2017. However they could not demonstrate how they had assessed people's needs or whether the increased staff level would meet people's needs in a timely and safe way. After the inspection we asked the provider to take action to assess people's needs and to demonstrate the staff levels were adequate. Since the inspection the

provider has completed a dependency tool as requested by CQC to assess people's level of need. They have submitted this to CQC along with weekly updates of the staff levels at the service.

The provider was actively recruiting to fill vacant staff positions. One new member of staff was due to start once their employment checks were completed. In the meantime the provider was using agency staff at the home where staff were unable to fill uncovered duties. On the second day of our visit there was an agency worker on duty. There was no system in place to check the agency workers identification when they arrived at the home. There was no induction for the agency worker to ensure they had the information they required to support people or about emergency procedures at the home. On the third day of the inspection, the manager had taken action to ensure agency staff identities were checked and that they received an induction regarding fire safety and call bells. An agency worker arrived on duty and staff were seen introducing them to the homes procedures. The manager said because of the current need to use agency staff to ensure staffing levels were sufficient; they were working with the agency to ensure they used the same agency staff, wherever possible. This meant agency staff would know the people they were working with and would be familiar with the service.

The manager, since they had taken up position, had ensured staff recruited had all the necessary checks made before they commenced employment. Recruitment files had completed application forms and pre-employment checks, including references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The manager was implementing a checklist to ensure all the required checks were undertaken. They said they would review all staff employment files to ensure they all had the correct checks in place.

People were not protected from the risks of unsuitable premises and equipment. When we visited on 20 September 2017 we identified serious risks related to the premises. We found water temperatures in excess of 50°C in five people's bedroom sinks and two communal bathrooms sinks. These exceeded the Health and Safety Executive (HSE) recommended maximum water temperatures (No hotter than 44 °C should be discharged from outlets that may be accessible to vulnerable people). Although there were small warning signs to advise people of the hot water this represented a serious risk of scalds for vulnerable people who lived at the home. There were no checks of water temperatures to ensure people were not at risk of scalds. Checks on the safety and integrity of bedrails and wheelchairs had not been carried out. There were no records in relation to whether bedrails and beds had been assessed for safety for each person to minimise the risk of them getting trapped or falling.

The environment had not been assessed to ascertain any risks posed to people. For example, there was a large pond in the courtyard at the centre of the home with three doors leading onto the area. This posed a risk to some people at the service who were living with dementia, had poor sight and who may not be aware of risks to themselves. We asked to see the environmental risk assessments, but were told there were none to assess the safety of the service. Therefore no assessment to mitigate the risks to people of any potential hazards had taken place.

There was no system in place to make sure the service was meeting the fire regulations. A fire risk assessment had not been completed to identify areas of concern in relation to fire risks. An external company undertook regular fire panel and fire extinguisher checks. However there were no records to show that fire drills and fire checks had been regularly completed as required by the 'The Regulatory Reform (Fire Safety) Order 2005.' This meant there was insufficient assurance that the home was safe in the event of a fire.

There were no individual personal emergency evacuation plans (PEEPs) which took account of people's mobility and communication needs. In the event of a fire, care staff would not be able to provide emergency services staff with written information about people which would aid their evacuation. This meant that it would be more difficult to evacuate people safely. We highlighted to the manager and to the provider that a medicine fridge and two armchairs were at the bottom of the staircase just inside the main entrance. These posed a significant risk to people in the event of a fire as the route was a main evacuation exit. A fire officer who had visited the home 18 months prior to the inspection said they had also advised that these items needed moving. The provider removed these by the third day of our visit.

Windows on the first floor of the service were restricted. However there were no checks undertaken to ensure the safety and integrity of window restrictors to keep people safe from falling out of windows.

There were no individual risk assessments undertaken for people to assess how to reduce risks as much as possible. There were no assessment of people's risks of falls, their skin integrity, nutrition and what support they needed when moving. There were no records of appropriate actions that staff should follow to address the risks. For example, one person had developed a recurrent pressure area often called 'bed sores'. There had been no assessment to identify the risk of skin breakdown and therefore appropriate actions, such as using pressure relieving equipment, had not been implemented. Another person was having a pureed diet, however there was no risk assessment to assess this person's ability to swallow and their risk of choking. This meant there was no plan of care to guide staff in how to manage the person to ensure they received the appropriate support when eating and drinking.

People's weights had been recorded however there was no system to monitor people's weights and to take action when someone had lost weight. We identified one person who had lost weight since April 2017. Staff had recorded in the daily notes 'still not eating much, has taken some fluids.' However there had been no monitoring of the person's dietary intake or referrals to the GP or to a dietician.

Staff had recorded accidents promptly in the accident books and the actions they had taken at the time. For example one person had five accident reports dated between 30 March 2017 and 16 April 2017, although none had resulted in any injuries. However no actions had been taken to try and prevent further accidents. There was no system to monitor the number of incidents and falls people had, to look at trends and themes. Therefore no action had been taken to try and mitigate the risk of further accidents occurring.

The above examples are all a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the concerns identified on the first day of inspection we wrote to the provider on 21 September 2017. They said they would take action in response to the concerns. This included, undertaking a risk assessment of the pond. On the third day of inspection the provider had alarms fitted on each of the three doors leading to the pond in the courtyard. The alarms would alert staff when opened. The provider said they had also spoken with an external contractor about the options to make the courtyard safe; these included fencing around the pond or a metal grid across the top.

In response to our concern regarding the hot water temperatures, the provider said an external contractor had advised them to fit thermostatic mixing valves (TMV's) to control hot water temperatures in all sinks accessible to people. They said this work would be completed by the 14 October 2017 and measures had been taken in the meantime to put in place larger signage to advise people of the risks.

They gave us assurances that they would complete a fire risk assessment and book staff training in health

and safety which would include fire safety procedures. They also said they would implement PEEPs for people.

However we were not totally satisfied with all of the actions and time scales proposed by the provider in response to our letter. We therefore served a Notice of Decision (NoD) on 28 September 2017 to impose conditions on the provider's registration. The NoD detailed the actions we required the provider to undertake within a given timescale. Providers are required to comply with NoDs or face possible further enforcement action. The provider took the actions required in the NoD and submitted the relevant information requested to CQC within the timeframes requested. We have since the inspection spoken with the provider and manager and received further assurances that actions have been taken to keep people safe.

On the 21 September 2017 we raised our concerns with the local fire officer. The manager also contacted the fire officer to ask their advice. The fire officer has since the inspection visited the service and is working with them to put in place a fire risk assessment and checks to meet the fire regulations.

People and visitors said they felt the service was safe and were happy. People's comments included, "I am very happy here, I have no worries" and "Absolutely wonderful, always warm and cosy."

People were protected by staff who were aware of the signs of abuse and wanted to keep people safe. Training records showed only seven out of 21 staff had received training in safeguarding vulnerable adults. However staff said they would report abuse both internally to management and externally to outside agencies if required. They said they had confidence in the manager to take action. One staff member said, "No excuse, I would report to the manager."

The manager and deputy manager had been working to ensure there was a safe system in place for the management and review of medicines. They had recognised there were areas for improvement and had taken action to put measures in place. The deputy manager said, "Medicines are fine, we are bringing them all in line, we have, on an odd occasion, run out but we are trying to improve." The improvements included ensuring medicines were ordered at timely interval, a stock balance was maintained and audits were carried out. The manager and deputy were in the process of taking action to reduce the excess stock of medicines and were adding recent photographs for all people to their medicine administration record (MAR) to help staff identify the correct person. They were also introducing a system to ensure people had their prescribed creams administered correctly. They were introducing a new cream charts with a body map to guide staff about which cream to use, where to apply it and the frequency of use.

Only staff who had received training, administered people's medicines. Staff understood the importance of following the correct procedures. MARs were accurately completed with no signature gaps and indicated if the person had any known adverse reactions to medicines.

Where people had medicines prescribed as needed (known as PRN), there were no protocols in place for when and how they should be used, which is good practice. The pharmacist who supported the service had given the manager a document to record these. The manager said they would ensure all PRN medicines had an appropriate protocol in place. This would help to ensure there was a consistent approach.

Medicines which required refrigeration were stored at the recommended temperature. Staff had recorded daily the temperature of the fridge. However there was no guidance to make staff aware of the recommended temperatures and the procedure they should take when the fridge temperature was outside the recommended range. The manager said she would speak with the pharmacist and have this put into

place. A review in February 2017 by the pharmacy providing medicines at the home did not raise any significant concerns.

External contractors undertook regular servicing and testing of moving and handling equipment and the fire panel and extinguishers. The manager said they would be asking the external contractor to increase the checks relating to fire prevention, for example, emergency lighting and fire doors. The manager had set up a book where they recorded repairs and faulty equipment. The provider used an external contactor to undertake any maintenance issues. The manager said they let them know the issue and the contractor came and undertook the repair and then invoiced the provider. The home appeared in a good state of repair and we found no issues relating to the maintenance.

There were Legionella controls in place, (Legionella is a bacteria that can grow in hot water systems which can cause a serious pneumonia like illness). A risk assessment had been undertaken in August 2015 by an external company. The recommended checks had been completed as required. This meant there were control measures in place to prevent or reduce the risk of Legionella infection.

Requires Improvement

Is the service effective?

Our findings

People's needs were not met by staff who had the right competencies, knowledge and qualifications. The manager had produced a staff training matrix for the home. The training matrix demonstrated poor staff compliance with the majority of the provider's mandatory training. For example out of the 21 staff recorded on the training matrix only one member of staff had completed fire prevention training; seven had completed safeguarding adults, which includes the Mental Capacity Act (MCA) and three had completed health and safety training.

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

A larger proportion of staff had completed some of the training; for example16 staff had completed moving and handling; 15 had completed basic food hygiene and 11 had completed first aid. Six staff had a higher qualification in health and social care.

The manager had recognised in the providers information return (PIR) that there were training gaps. They had already arranged with an external trainer who provided face to face training, to deliver fire training to staff on 29 September and the 3 October 2017. The manager said they wanted to ensure staff knew how to keep people safe in the event of a fire. They were also working with a training provider to put in place a training schedule to ensure staff complete the mandatory training. The manager had also identified that staff required training in relation to record keeping and had arranged training with the local nurse educators. They confirmed that there was other training, specific to people's individual needs, which staff required and they would be looking to source the required training.

People who lacked mental capacity to take particular decisions were not protected. The provider had not acted in accordance with the Mental Capacity Act 2005 (MCA). The 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were not always protected as staff did not have a clear understanding of the MCA and what constitutes restrictive practices. For example, there was a keypad on the front door of the home to prevent some people leaving unaccompanied. However there had been no capacity assessments undertaken to ascertain if people should have restrictions on their freedom. One application had been submitted to the local DoLS team which had been authorised. However not all the staff were aware that this person had a DoLS in place. There was no information in the person's care plan to make staff aware of how to support them in a consistent way and in the least restrictive manner.

Staff had not considered people's capacity to make particular decisions. There were no documents to demonstrate where a person lacked capacity; staff had involved the person, family members and other professionals in 'best interest' decision making. For example, in relation to the use of bed rails or the use of 'sensor mats'.

Staff involved people in day-to-day decisions about their care and treatment. However staff had a very limited knowledge about the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and associated codes of practice. Only a few staff undertaken any training regarding the MCA.

Staff were not always aware where people had nominated a relative as a Lasting Power of Attorney (LPA) to make decisions about their finances and/or their care and treatment. LPA is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if either they are unable to at some time in the future or no longer wish to make decisions. There was a place on the front sheet of people's care records for staff to record if they had delegated a POA. However this was not always completed and, where it had been completed, it was not recorded what type of POA was held. Therefore staff might not involve the LPA appropriately in decision making about a person's care. The manager was not aware of having any copies of people's power of attorney in order to ensure they were acting on people's wishes.

The above examples are all a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said they would ensure staff undertook training regarding the MCA. They also said they would identify who had a POA and obtain copies so the staff would be aware of the POA's authority.

The manager had set up a supervision programme and had undertaken one-to-one supervisions with all staff. They said this was to get to know staff, see what support they needed and to ask them what they felt were the main issues at the service.

People had access to healthcare services for ongoing healthcare support. People were seen regularly by their local GP, and had regular appointments with the dentist, optician, and chiropodist. People's medical history and health needs were recorded when they were admitted to the home. The care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health.

Staff had not taken timely action in two instances where people required health professional input. These were when staff had recorded a person had lost weight they had not contacted the person's GP or consulted a dietician. Another person's care plans did not demonstrate how decisions had been made regarding the consistency of their diet and whether the speech and language team (SALT) had been involved in the decision. We raised these concerns with the manager who said they would review both concerns. At other times staff worked with health professionals such as the community nurses. Health care professionals said they were contacted promptly. They said staff were recognising that people's conditions sometimes changed and were proactive in their response. For example, identifying that a person had a sore bottom and that a person was not their usual self.

The health professionals were all aware of the new manager and were positive about the changes the manager was implementing. Four of them said that they had been aware the paperwork at the home was not up to standard but said they felt the delivery of care was very good. They said they had confidence in the new manager who was bringing in better paperwork. Comments included, "Staff are really nice, caring.

There is always a nice atmosphere here. I have no concerns about pressure care"; "No concerns, paperwork has always been a problem here. They have always made sure care has been up to scratch. Our patients always look well cared for. They don't have a blemish on them. They have always been very particular who they employ here … quality staff" and "(The home is) always clean, does not smell, always someone to show us around and are completely open and honest. The communication between us has been good and the poor paperwork hasn't impacted. If they have a problem they pick up the phone."

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu with one meal choice. The cook said people could have an alternative if they chose. They said they had met with the manager and that they were looking to improve meals at the home. The manager said there had been breakfast cards in use at the home. This meant each morning staff would give people the same breakfast as agreed when they first came to the home. They were in the process of changing this so people were asked the previous day what they would like for breakfast the following morning.

People and relatives were mainly positive about the food at the home. Comments included, "The food is jolly good, I find out when I walk through the door what's for lunch"; "I am not fussy. I don't know what would happen if I didn't like the food, I have never said. There is plenty of food"; "Lack of variety …it is freshly cooked food. Basic but good" and "The food is very good."

In the kitchen there was a list of people's dietary needs, likes and dislikes. For example, who had diabetes. Two people were identified on this list as needing a diabetic menu. We discussed this with the manager as it was not clear from these people's care records if they were diabetic. The manager said they would contact the people's GP to ascertain whether the two people were diabetic and put in place clear guidance to staff. Care records did not show whether people who had a pureed diet had been assessed by a speech and language therapist (SALT) regarding their swallowing difficulties. Therefore it was not clear who had recommended that these people were given pureed food. On the first day of our visit all the meal was pureed together, which meant people were not able to differentiate between different food items, such as meat and potato. This meant that it did not appear appetising. We discussed this with the cook and on the second and third day, each food item was pureed separately. A care worker commented, "Doesn't that look more appetising."

There were jugs of water and juice available for people and staff offered regular refreshments. The manager had recently moved the location of the dining room. People, visitors and staff were positive about the new location. The dining room tables were well presented with table cloths, place mats, condiments and a small flower arrangement. We observed two meal times in the dining room. Staff were very attentive and responded quickly to people's requests.

Requires Improvement

Is the service caring?

Our findings

Staff didn't always treat people with dignity and respect when helping them with daily living tasks. People were placed in wheelchairs in the morning and remained in those chairs until they went to bed in the evening unless they requested to be repositioned or to use the toilet. The wheelchairs were designed for transporting people, not for sitting in all day. One care worker said, "If they want to go (to the toilet) they will ask… normally left in pads and left in wheelchairs." The manager had addressed this by our third visit and people were having their continence needs met and not being left sat in wheelchairs.

Staff said they had been told in the past not to use the hoist in the communal areas at the service. Therefore people who required the use of a hoist were placed in wheelchairs for the day. This meant staff could take them to their rooms if they required repositioning. We discussed this with the manager and by the third day of our visit, this had changed. People were not placed in wheelchairs for the day they were supported to sit in comfy armchairs. If staff needed to move them they would use the hoist in the communal areas ensuring people maintained their dignity. For example, by placing a blanket over their legs.

People were supported by caring staff who treated them with kindness. People said, "The care is very good"; "They ask if we are alright, very caring" and "They are lovely here."

Staff maintained people's privacy and dignity when assisting with intimate care. For example, staff knocked on people's bedroom doors before entering and gained consent before providing care.

Throughout our visits staff were respectful in their manner. They greeted people with a smile and people responded positively. Staff were busy and were mostly interacting with people when they were providing support. Staff were pleasant in their manner with people and at times happy banter was heard. Staff supported people eating their lunch when required. Two care workers were supporting people to eat their lunch in their rooms. They were sat next to the person and did not rush them and were heard talking throughout to give them reassurance

People seemed to know the staff well and were seen positively interacting with some. One person became very distressed after lunch on the first day. Two care workers took the person to a private area and then one care worker sat for about twenty minutes interacting and reassuring the person. Eventually the person appeared to relax and they decided they wanted to go to bed and have a rest which staff facilitated.

Staff involved people in their care and supported them to make daily choices while they were undertaking their care. For example, people chose the clothes they wore and how they wanted their hair. One person commented, "Can go to bed pretty well when you like." Another told us about how they chose to sit in the lounge and would go to the dining room for lunch. Another person chose to have their lunch in the new through-lounge which staff arranged for them. One person said how they were particularly fond of one of the care workers who took time to do their hair as they chose.

There was a pleasant atmosphere at the home. People's rooms were personalised with their personal

possessions, photographs and furniture. People's relatives and friends were able to visit without being unnecessarily restricted. People said their visitors were made to feel welcome when they visited the home. Visitors were made welcome during our visits by staff and confirmed they could visit when they chose.

One person was receiving end of life care at the home at the time of our visit. The staff worked closely with the person's family and GP to ensure they were informed. Two health professionals praised the end of life care given to the person saying, "Impeccable end of life care." They explained how staff had regularly repositioned the person to make them comfortable and to stop their skin from becoming sore. They said they had been called because the person required some medicines because they were agitated. A staff member had stayed with the person until they had arrived to help reassure them and reduce their agitation. However end of life care planning had not taken place so we could not be assured people's needs were known and met.

Requires Improvement

Is the service responsive?

Our findings

People were not always at the centre of the care they received. The provider had not ensured that people received person-centred care that met their needs and reflected their preferences. Staff at the home were identifying concerns and changes in people's presentation and were calling health professionals because of these concerns. However care plans did not reflect people's needs, choices and preferences.

The care plans had headings which included personal hygiene, medication, dietary needs, mobility, sensory ability, psychological needs and faecal and urinary incontinence. However the level of guidance in each of these sections of care plans was very minimal and did not always reflect the person's needs. For example, one person had previously had a hip replacement; however there was no guidance in the persons care plan on how to manage their mobility safely. Another person's mobility care plan stated the person used a frame and required care staff to support them for short distances and a wheelchair for long distances. However this person did not mobilise and required staff to change their position with the use of a hoist. Another person had a pureed diet; this was not referred to in their care plan. Therefore this person was at risk of receiving the incorrect consistency of food which could cause them to choke. A fourth person had a broken area of skin; there was no care plan to guide staff how to support the person to help heal this. However staff had taken the decision to keep the person on bed rest, with regular repositioning and had contacted the community nurse team for input.

People, or where appropriate, their relatives were not involved in reviewing their care, support and treatment plans to ensure they reflected the way they preferred their care. There was no system to ensure care plans were regularly reviewed to update them with people's changing needs. Some care plans had not been reviewed by staff since October 2016 and did not reflect people's current needs. However relatives said they were always contacted and informed of any changes.

Daily records did not contain very much detail about how people were each day. Staff had made entries each day but they referred to the actions staff had taken. For example assisted with personal care or slept well. One entry did state a person had a very dry cough and yet a week later no further entries had been made regarding this person's cough or any actions taken. This meant the systems in use to relay information were not always effective. The manager had recognised this and had scheduled some training with the nurse educator team.

The above examples are all a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager confirmed after the inspection that action had been taken and they were monitoring the person more closely. Following the inspection we raised our concerns with the local authority safeguarding team.

The manager had recognised the care plans needed to be reviewed. They had recorded in the provider information return (PIR) which was submitted on 11 August 2017 that they wanted to 'introduce more

focused individualised care plans'. Before our visits the manager had discussed with the provider implementing a new care plan system. This was demonstrated on the second day of our visit when the provider arrived with printed templates in order for staff to populate. The provider confirmed they had concerns about the quality of the care plans. They said, "I haven't seen a care plan like this before."

Handover between staff at the start of each shift ensured that information about people was shared. For example, one person had developed bruises; staff were aware of this and had contacted the person's GP. There was a small consistent staff team who communicated well to each other during our visits. This meant staff were informed of people's daily changing needs.

The provider did not have a system in place regarding complaints. The complaints procedure did not guide people how to raise a concern and the process that would be undertaken. Therefore people had not been advised about external agencies they could contact if they had a complaint about the service. The provider said they had received a concern regarding the cleanliness of a person's room. They had emailed the complainant a response but had not recorded this concern.

The above examples are all a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said they would implement a complaints procedure and a system to record complaints according to the new policy when it was put into place. People and visitors said they would be happy to raise concerns with the manager and staff and said they would be confident they would take action. One person commented, "There is a very good girl, I would tell her, I think she would put me on right road what to do." A second said, "If I have a concern I can tell any of them and happy they would sort it out."

The provider had spoken with people, staff and families during their visits. This was confirmed by a person, a relative and two staff. The provider said they had given out their email address and telephone number so people could contact them if required.

People were supported to follow their interests and take part in social activities. A staff member had additional hours in the afternoon to undertake activities with people. The manager had met with the staff member and was looking at improving the documentation of activities and to improve the range of activities offered. Examples of activities provided at the service included, bingo, exercise classes, visits from PAT (Pets As Therapy) dogs, art classes, pampering sessions and reminiscence. Staff would inform people of the activities available at the service each day. On the third day of our visit staff had set up a brightly coloured activity board telling people about what was coming up at the service.

The provider had purchased a minibus for people to be able to go on outings. Comments were positive about the minibus. One relative said about how their family member had not been outside for a long time and how much they had enjoyed their first outing.

The staff member who organised the activities also spent time with people in their rooms to ensure they were not at risk of social isolation. They gave examples, where they had supported one person by giving them a hand massage and talking about things the person liked.

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager as a condition of registration. Southlands Court did not have a registered manager at the time of inspection; the previous registered manager last worked at the home in June 2017 and had since left the employment of the provider. The assistant manager had taken up the position of manager in August 2017. They have submitted an application to CQC to become the registered manager at the service. They were appointed as the new manager from the 1 August 2017. A new deputy manager had started at the service four weeks before our inspection. In the first two weeks they had undertaken an induction.

On the first day of our inspection both the manager and the deputy manager were very clear that they had not been able to find many records relating to the running of the service. This was confirmed by the provider on the second day of our visit. Therefore there were no records of audits with the exception of legionella checks. The provider could not demonstrate that they had ensured the environment was safe and that care and support was being well-planned or action being taken to mitigate risks relating to people's health and welfare. There were no quality assurance systems or processes in place to make sure areas for improvement were identified and addressed.

We identified a number of breaches during the inspection which had not been identified by the provider because there were no systems to monitor the service. For example, checks on the environment or people's care records had not been carried out which meant that there were risks to people's health and safety. Staff training had not been monitored which meant a large number of staff were not up to date with the required training. Care records did not adequately describe people's risks, needs and preferences or how these should be addressed. No tools had been used to assess the level of need and staffing levels were insufficient to ensure that people's needs were met. Some policies and procedures, such as one to deal with complaints were not available.

A folder of 25 policies and procedures had been put together and reviewed by the previous registered manager in July 2016. These did not reflect the practice at the service. For example, the dementia risk policy stated, 'The manager ensures needs assessments in these respects are comprehensive, include risk assessments and involve other appropriate professionals…'. This had not taken place for one person. The nutrition and hydration policy recorded that a 'nutritional assessment to identify individual needs, likes and dislikes of food and who is potentially at risk of malnutrition… will form part of the service user's person centred care plan and ongoing review'. This had not been undertaken. The fire safety policy stated, 'a risk assessment should be carried out for each resident…in relation to fire and evacuation procedure'. This had not been completed. Therefore the policies in use were ineffective and not being followed. The provider and manager were unaware of these policies and their contents. They said they would develop a policy folder which would be regularly reviewed to reflect the service and ensure procedures and processes were put in place as set out in the policies.

The provider visited the home most weeks to support the management team. However they had not formally recorded their visits so there was no written evidence of where they had identified issues and the

actions taken in response. They said they had been dependent on the feedback given to them which was that "everything was fine".

There had been no meetings held or surveys undertaken to ask people and relatives their views about the service. This meant people and their families were not being given opportunities to be actively involved in developing the service.

The above examples are all a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were very concerned about some of the findings during the first two days of our inspection visits about the lack of monitoring of the service and the risks this posed to people. Therefore, on 21 September 2017, we wrote to the provider setting out our concerns and asking them how they planned to ensure people living at Southlands Court were being kept safe. The provider's response acknowledged the concerns raised and gave a commitment to addressing them. However, CQC did not feel the response setting out the actions to assess the service and to put in place safety systems were sufficiently detailed and were being planned to be done in a timely way. The CQC therefore used urgent enforcement powers to impose conditions on the provider's registration under section 31 of the Health and Social Care Act 2008. The conditions set out what actions we required the provider to take and the timescales in which the actions needed to be completed. They were required to undertake audits and risks assessments and formulate an action plan. They were then required to send the action plan and regular updates to CQC each month so we can monitor the progress being made.

The audits and assessments we asked the provider to complete included an environmental risk assessment, monitoring of hot water temperatures, windows restrictors and bedrails' an analysis of falls and accidents at the home to assess if there were any patterns or trends which could identify risks which could be mitigated. We also asked that they complete individual risk assessments for each person in relation to their individual needs. Since CQC issued the conditions on the provider's registration the provider has undertaken the required audits and risk assessments and has submitted the actions they have taken to CQC as required. We have since the inspection spoken with the provider and manager and received further assurances that audits have been completed and systems have been put into place to undertake regular monitoring in order to mitigate further risks.

The provider is required by law to send CQC notifications about important events at the service. For example, deaths, serious injuries or safeguarding concerns. We had not received notifications from the provider since March 2017. The manager said there had been two deaths at the service which we had not been notified about. Since the inspection, these have been submitted retrospectively.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

The new manager said their main priorities since taking over as the manager were care plans, medication and kitchen issues. The question 'What do you do to ensure the service you provide is Well-led?' In the provider information return (PIR), the manager had responded, 'Keeping an open door, if anyone has any issues they wish to discuss. To follow the six c's, care, compassion, competence, communication, courage, and commitment.' The manager told us they recognised there were a lot of areas which required improvement and said they were working with the provider and staff to implement these. They described how they had confidence in the deputy manager to support them to make the improvements, saying, "We are both singing from the same book."

The manager had recognised the importance of actively involving staff in developing the service. They said there had been some resistance from staff who felt, 'Why change it because it works?' They had already held meetings with staff and said further meetings would be held regularly to discuss concerns and changes which were being implemented. Staff said they had confidence in the provider and manager. Comments included, "The service got a bit lacksy daisy but (manager) is trying to sort it out"; "It is going to be a good place, there was room for improvement, management and staffing which is being sorted. (Manager) is looking at it…it is early days, it need time to feel how it's working. It was left in a bit of a state" and "Things are improving. (Manager) had a lot to take on, she listens to us. Given time I am sure (manager) can sort it out. (The provider) is aware and wants it to turn around."

The provider said the reason they had purchased the service was because they liked the care and atmosphere at the home and the way staff interacted with people. They said they had recognised the service had been run "very haphazard" and had been taking action to put a stronger team in place. Their main concern was the paperwork, care plans, lack of supervisions and not having any audits. They said we need "time to get on top of things."

People and relatives said they had met the manager and had confidence in them and the changes being made. Comments included, "I can't fault the girls, since the management has changed the feel of the place has improved, a nicer feel": "Everybody's spirits have lifted since (manager) arrived" and "I prefer it now, since the new provider, staff look younger and more interested."

However there were only two formal systems to ask people and their families about their views about the service. One was a suggestion box in the main entrance and information cards to guide people to a review on their website. There had been one review on the nominated website in May 2017 which recorded, "Change of recent ownership is taking a little time for 'dust to settle'. Reception by all staff is warm and very welcoming." The provider said they had not received any suggestions from the suggestion box.
In April 2017 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored three with the highest rating being five. The provider had actioned some of the concerns identified. This included making changes to a hatch in the dry store cupboard and making changes to the sanitiser being used in the kitchen. The manager was working with staff to implement the required documentation and were in discussions about how to reduce staff needing to go into the kitchen. This showed the provider was working to improve the food standards and record keeping in relation to food hygiene at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission without delay of incidents specified in paragraph (2) 18(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured the care and treatment of people was appropriate, meeting their needs or reflecting their preferences. 9(1)(a)(b)(c)(3)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured people were only provided with care and treatment with the consent of the relevant people. They had not acted in accordance with the Mental Capacity Act 2005 11(1)(2)(3)(4)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an established system for identifying, receiving, recording,

handling and responding to complaints.
16(1)(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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed the health and safety risks to people. They had not ensured the premises were safe. 12(1)(2)(a)(b(c)(d)(e)

The enforcement action we took:

On the 28 September 2017 the Care Quality Commission issued an urgent notice of decision to impose conditions on the provider's registration.

The registered person must complete an initial audit of;
(a) Environmental risks, including the pond.
(b) Hot water and surfaces, this should include risks associated with hot water used for showering and bathing and take account of the Health and Safety Executive guidance.
(c) All service users risk assessments.
(d) Service user falls and accidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems or processes established to assess, monitor and improve the quality and safety of the service provided. 17(1)(2)(a)(b)(c)

The enforcement action we took:

The registered person must implement a system of internal audit and submit a report of the outcome of these audits and any associated action plans to mitigate identified risks to the Care Quality Commission by 22 October 2017 and thereafter on the final day of each calendar month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured they had sufficient numbers of suitably qualified staff to meet

people's needs.

18(1)(2)(a)

The enforcement action we took:

The registered person must have a service user dependency and staffing capacity tool in place to determine the number of staff and range of skills required in order to meet the needs of service users using the service. This must be kept under regular review. This outcome of this assessment with the identified staffing levels must be submitted to the Care Quality Commission by 6 October 2017.