Southfield House Limited

Southfield House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 13 July 2016 and was followed by an announced visit on the 15 July 2016. We last inspected the service in January 2014. At that inspection we found the service was meeting all the regulations that we inspected.

The Southfield House provides residential care for up to 23 people, some of whom are living with early onset dementia.

The service consisted of a main building and an adjourning extension called Norwood. People who were more independent and required less support lived in Norwood. Staff referred to this part of the building as the 'assisted community.' At the time of our inspection there were 21 people living at the service, 15 people lived in the main building and six in Norwood.

The service had a registered manager in post. 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. The registered manager also owned the service with their partner who was appointed as a director.

People said Southfield House was a comfortable place to live with well cultivated gardens surrounding the home. Thought and attention had been given to the homely feel of the service, including fresh flowers in communal areas and the service was kept clean and tidy. Staff kept the home free from obstacles and trip hazards so people could move around safely. Risks to personal safety had been assessed and steps were taken to prevent avoidable harm. The premises and equipment were checked and maintained to ensure they were safe.

We found that staff training was out of date in some cases and needed to be improved.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. There were measures in place for supporting people to take their prescribed medicines safely.

There were enough staff to support people in the service and to meet their needs. The provider had carried out appropriate checks to ensure staff were suitable and fit to support people. Staff received appropriate support. They had a good understanding of people's needs and how these should be met.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their

liberty. We found the provider was complying with their legal requirements.

People were supported to have enough to eat and drink and able to make choices about what they wanted. Each mealtime consisted of a number of alternative dishes to meet people's preferences. Where people required changes to their diets, the consistency of their food, or required support from staff, this was provided. People who required closer scrutiny of their food and fluid intake because of identified risks, were monitored and people were referred to specialist healthcare professionals where required.

People had developed good relationships with staff who were caring, compassionate and sensitive. People were treated with respect and their dignity was promoted. When upset or anxious, people were reassured by staff who understood them. People were helped to retain their independence whether eating, drinking, walking around or helping with the housework. People's feedback was sought on a day-to-day basis so that any changes to their activities or meal choices could be made quickly.

There was a complaints procedure and feedback systems in place to obtain people's views and allow them to complain if that was required.

There was a quality assurance system in place to ensure all aspects of the service were routinely audited and checked. Senior staff used these checks to assess and review the quality of service people experienced. Where shortfalls or gaps were identified senior staff addressed these promptly.

We found one breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staffing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew what action to take to protect people from abuse or harm and to minimise identified risks to people's health, safety and wellbeing.

Regular checks of the premises and equipment were carried out to ensure these were safe.

There were enough staff to support people with their care and support needs. The provider carried out appropriate checks on staff to make sure they were suitable and fit to work at the home.

Staff ensured people received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had completed training but this needed to be refreshed.

People's rights were respected. Staff had an understanding of the Mental Capacity Act 2005.

People were supported to have enough to eat and drink. People were encouraged to make choices about their meals and these met their preferences.

Is the service caring?

Good

The service was caring.

People had developed positive relationships with staff, who treated them with kindness, sensitivity and respect.

Staff understood people well and we saw examples of this.

People were encouraged to maintain their independence and express their thoughts about their care and support on a daily basis.

Is the service responsive?

Good

The service was responsive.

People were supported to live an active life.

Staff encouraged and supported people to participate in a range of activities to promote conversation, interaction and social inclusion.

People were involved in planning and making decisions about their care and support needs and care plans reflected people's choices and preferences for how they were supported.

People and relatives were comfortable raising issues if they needed to and the provider had arrangements in place to deal with complaints and issues appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

An experienced registered manager was in post who led and supported the staff team, with support from a deputy manager.

Feedback was actively sought and acted upon, enabling people and their families to influence how the service was run.

Systems were in place for assessing and monitoring the quality of the service that people received.

Southfield House Residential 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 13 July 2016 and was unannounced. This was followed by an announced visit on 15 July 2016. The inspection was carried out by one inspector.

Before the inspection, 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 this as part of our planning of the inspection.

We reviewed other information we held about the home, including any notifications we had received from the provider about deaths or other incidents.

We placed posters on display within the service to let people and visitors know that we were inspecting. The posters also included contact numbers and who to get in touch with if they wanted to speak with us after the inspection in private.

We spoke with 10 people who used the service and seven family members/carers. We spoke with the registered manager, the deputy manager, the chef and six other members of care staff. We spoke with the facilities administration manager and also one of the owners/directors of the service who visited. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for four of the 21 people who used the service, three staff personnel files, health and safety information and other documents related to the management of the home.

After the site visit, we contacted district nursing teams, infection control teams and the local GP surgery and where we received responses, used these to further support our judgement.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I lived alone before, so this is much better. I have the company of others and feel very safe here." Another person said, "It's not home, but towards the end of being there I did not feel safe. I was frightened of falling. I have to say, I don't worry so much about that side of things now." All of the relatives we spoke with confirmed that they thought their relatives and their belongings were safe.

When we arrived at the inspection we were asked to sign in a visitor book. We noted that other visitors to the service had done the same on previous days. This meant that it helped to prevent unauthorised visitors being in the building without being accounted for and meant in the event of an evacuation being required, emergency services would be able to account for everyone at the service.

One relative mentioned that not all staff wore their identity badges (ID), and we noticed this was the case during the site visit. They told us, "When you visit, sometimes you forget staff names and it would be nice to see their names so you don't have to ask. Also if someone is new it helps." This also meant that people with memory issues may not always find it easy to recall names and staff ID's are aids which can help them. We spoke with the registered manager about this and she told us that staff have ID and should be wearing it. She said she would look into the matter.

Staff had assessed the potential risk factors for people who lived at the service. For example, those at risk of falls, those at risk when being moved and handled and those at risk of poor nutrition or those at risk in connection with their dementia diagnosis. We saw that risk assessments had been completed for each individual where any risks had been identified and any actions to reduce the risk were recorded. For example, one person was at risk of falls and it was recorded that staff should ensure that the correct footwear was worn at all times. This meant that staff took action to minimise the potential risk to people who lived at the service.

Fire equipment was checked and practice fire drills were carried out. The annual fire risk assessment was in place and work was being finalised relating to points raised. Checks on the premises and equipment had been completed, including the five year mains electrical installations, where the contractor described the electrical system as in good condition. Gas supply checks and checks on the working order of the lift had also been completed and all were in satisfactory order.

Practical training was completed with staff around the use of fire extinguishing equipment and we saw a store of these used for this purpose. The deputy manager told us, "The registered manager thought it would be a good idea to do that [practical training] with staff." We asked staff about fire evacuation procedures and they were aware of what actions needed to be followed should an emergency of that kind arise. One staff member told us, "We know how to use those [extinguishers] but also know when we need to call for the fire brigade and not try to deal with things [fires] ourselves." Personal evacuation plans were being reviewed for people which would be used in the event of an evacuation being required, for example, in a fire or flood.

The provider had a contingency plan in place for any emergency event, for example lift failure. Staff had written instructions on what they should do and who they should call, including for example, talking to trapped people (if any) and reassuring them with regular updates.

We observed medicines administration within the service and found that this was carried out safely. Medicines were stored securely, including checks on room temperatures being completed to ensure the effectiveness of medicines was maintained. The majority of medicines remain effective when the temperature reaches no more that 25 degrees Celsius. Medicines due for disposal were stored safely and dealt with effectively and had just been collected by the pharmacist the day before. People told us they received their medicines and at a time that suited them. One person said, "Oh yes dear, the girls give me my medicines when they should. Never had any problems." The relatives that we spoke with were not aware of any concerns with the management of their family members medicines and one relative said, "Absolutely no issues."

We noted that there was not always guidance in people's medicines records of how topical creams should be used. Topical creams are most often applied to body surfaces such as the skin to treat ailments. We spoke with the deputy manager about this on the first day of the site visit and by the second day, this missing information had been updated.

We noted that the service had the use of an out of date BNF book. The British National Formulary (BNF) is a pharmaceutical reference book that contains information and advice on prescribing medicines. We spoke with the registered manager about this and they told us they would ask their pharmacy for a new copy.

First aid boxes were checked and we saw that one had become depleted in the 'sluice' room. One member of staff told us they had already mentioned it to the registered manager and it was going to be replenished. Staff were aware of the legal requirements to ensure that adequate first aid arrangements were in place and had taken measures to comply with this.

People told us and their relatives confirmed that they thought there was enough staff to support their needs. Although one person commented, "Some days seems busier than others and you may have to wait a little longer." During the site visit, staff were busy but were able to manage the daily needs of people who lived at the service. One staff member told us, "Residents needs are increasing over time, we have also seen that in new people coming to the home." The management team completed a staffing tool linked to people's dependency to ensure that enough staff were on duty. We looked at the most recent staffing tool completed and saw that the staff on duty matched with the number required by the tool to support people fully. The registered manager told us, "I am aware that residents needs vary, and we monitor this." The registered manager assured us that they would continue to monitor staffing numbers regularly. We looked at four weeks of staff rotas and confirmed that staffing levels remained static throughout. This meant that the provider had systems in place to monitor staffing levels and ensure that enough staff were on duty at all times.

We checked infection control procedures. Staff told us, and our own observations confirmed, that staff had access to personal protective equipment such as gloves and aprons. We saw all areas of the service were clean, and there were no malodours in any of the communal areas or bedrooms we checked. Staff used best practice infection control procedures when cleaning floors and used colour coded mops to ensure that cross contamination was minimised. For example, red mops for toilet areas and yellow mops for general areas.

We noted that used medicine administration 'pots' were washed and dried in an area near the sluice

facilities. A sluice room is where items used to support people with their personal care are cleaned and disinfected. We spoke with the registered manager about this and they said they would address this.

On the first day of the inspection we were made aware that care staff used kitchen areas at night when kitchen staff had finished their shift for the day. The area was used to make people snacks and any drinks they required. We were made aware that staff did not always use personal protective equipment when this occurred. We brought this to the attention of the deputy manager on duty and before we left the first day of inspection, staff were seen to be using gloves and aprons in this area. Although there had been no cross contamination issues within the service, this meant that people were further protected from potential future cross contamination risks. We noted that the service had received a 5 star food hygiene rating from the local authority environmental health department, which is the highest rating possible and meant that they were satisfied with levels of food hygiene at the service.

We checked the personal finances of people who had their money secured with the provider. Records were checked and found to be correct, as was the money held within the safe.

Safe recruitment practices were followed to ensure appropriate staff were employed at the service. All potential staff were required to complete an application form and attend an interview so that their knowledge, skills and values could be assessed. The provider undertook checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining references from previous employers and/or character references and Disclose and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received enough training to help them support people effectively. Staff had received training in a range of topics, including for example, emergency aid awareness, fire safety, moving and handling and food hygiene. We noted, however, that there were gaps in refresher training. For example, safeguarding vulnerable adults training should have been updated in December 2015 for all staff but only a small proportion had received this training. We also saw that infection control training had not been refreshed for all staff since 2014. This meant that although staff had received training, current best practice may not have been followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staffing.

One staff member told us, "The registered manager used to be a nurse and is very knowledgeable." Another member of staff told us, "Completed lots of training." All staff were qualified up to a minimum of level two in a health and social care related subject, with others qualified at level three, four or five. These qualifications were vocational qualifications, previously called National Vocational Qualifications (NVQ) and involved staff completing practice based work and then being assessed on this work by a visiting assessor.

We saw good examples of moving and handling procedures being carried out by a number of staff, including hoisting one person from a wheelchair to a comfortable chair and vice versa. Staff completed this task proficiently and the people they supported were at ease throughout. One person that used a stand aid said, "I never worry, they know what they are doing." Stand aids are pieces of equipment used to help people stand who need additional support.

We asked people and their relatives if they thought the service was effective and everyone we asked the question of told us they thought it was. One person said, "It's toppo." Another person told us, "When I need any help, I get it. If I need to see a doctor, I see them. To be honest - they are very good at sorting things out for me." One relative told us, "When [person's name] came to live here, I thought they would not settle, but they proved me wrong and I think that was down to how good the staff were with them. The staff managed to get [person's name] to do things, I never thought possible." Another relative told us, "They [staff] seem to do what they should, put it this way…..not had any problems."

We checked staff training and induction. Induction included, for example, training in safeguarding people from abuse, dealing with accidents and record keeping and access to files and we saw this demonstrated staff were given the skills to meet the 15 standards of the Care Certificate, although paperwork had not been formally changed. We saw the induction policy and this needed to be updated with changes in best practice and legislation. For example, the policy stated that staff followed the common induction standards with skills for care guidance and this was replaced by the Care Certificate in 2015. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaced the National Minimum Training Standards and the Common Induction Standards. We spoke with the registered manager about this and

they said they would update the policy and ensure that paperwork was updated accordingly as soon as possible.

Medicine competency checks were completed with staff by the registered and deputy managers and staff confirmed that this was the case. However, we noted that the checks were not recorded and the deputy manager was unable to show us any evidence. Although we were confident that this omission in recording had no impact on the people living at the service, the registered manager said that they would rectify this and agreed that the information would be included separately as part of the supervision process.

Staff supervision sessions were completed and staff told us they felt supported by their line manager. We saw that the deputy manager's record of supervisions had gaps, however, they confirmed that they felt they had opportunities to speak with the registered manager whenever they needed to. We observed that the deputy manager and the registered manager had a good working relationship and this assured us that any support which may have been required would have been given. Appraisals were completed for staff and we saw evidence of this on staff personnel records. We noted that staff had played a full part in this process and personal goals had been developed jointly. Supervision and appraisal is a process used by management for meeting with employees to manage their performance and provide opportunities to develop and improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is 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 and they were. We saw that two applications to deprive people of their liberty had been sent to the local authority for approval.

Copies of lasting power of attorney (LPA) were held by the provider. (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. Staff were aware of people who had a LPA in place which meant they would ensure that any decisions made were in consultation with the relevant appointed person.

Meal times were supported to be a social affair as well as a time to receive suitable nutrition. We observed breakfast, lunch and tea time meals. Meals were served in a light and airy dining room with access directly into the kitchen via a serving hatch, and for those who wished to have their meals in their bedroom, this was accommodated. The dining room overlooked the garden area and had patio doors which could be opened to increase air flow in warmer weather, the patio doors had secure railings to protect people from falling.

At every meal, we heard people chatting with each other and staff, including the chef and kitchen staff. People had a range of food options available to them, including hot and cold food and a variety of desserts and other snacks at various times of day. Refreshments were varied too, including for example a selection of fruit juices, water, tea and Horlicks. We saw one person had bacon and eggs for their breakfast, followed by a cooked meal at lunch time and sandwiches for tea with snacks in between.

People's dietary needs were considered. People living with diabetes had sugar free alternatives. Information

about any allergies people had were highlighted in their care records and in records held with in the kitchen. People's weights were monitored closely and additional strategies were put in place to help people who had lost weight or were at risk of losing weight, for example they were offered food fortified with full cream milk, butter and cream. People were encouraged to eat as independently as possible; this included providing suitable crockery to help people eat their meal. Staff were observed assessing when people needed prompting or help to eat their meals. One person was initially helped with their meal but staff withdrew prompting and encouraged them to eat their meal independently. We visited the kitchen which was clean and spoke with the chef during our inspection. They were in the process of serving lunch and we observed this in action. They knew people well and were able to describe which people liked particular foods and showed us a list of food allergies that people had. The chef also showed us a list of birthdays and told us that these were celebrated with a cake and a special 'tea'. We saw pictures of a number of birthday celebrations held within the service which were held in a photo album.

Everyone we spoke with said that they had easy access to their GP when they needed. People were supported by staff to see healthcare professionals such as GPs, specialist nurses, speech and language therapists, chiropodists, and dentists. We saw from people's records that they were referred to outside professionals without delay and the advice provided by these professionals was used to plan their care.

The service was adapted to support people with additional mobility needs, including those who used wheelchairs. We spent time walking around the internal and external areas of the service, including the large garden area with raised flower beds and greenhouse facilities. We found that access was good and enabled those with less agility, to be able to move around the service, including the garden with minimal support.

Good

Is the service caring?

Our findings

People were extremely positive about the care that staff provided them and their relatives confirmed this. Comments from people included; "There is lots of goodness here"; They are so kind"; "Very caring"; "I have found the manager and staff to be very caring and considerate" and "They're pretty good. I've not found any problems with staff."

Comments from relatives included; "The staff are really good. I can't fault any of them. They have built up a good rapport with [person's name]"; "Staff are as caring here as anywhere" and "I have no concerns around care, all the staff and the owners are very good."

One person was not well at the time of our inspection, and we saw that staff sat with them so they were not alone, when no relatives were present. This showed that the staff cared about the comfort and emotional support they offered to people who were not in the best of health.

We saw copies of an 'order of funeral' for one person which thanked the staff at the service for the care they had shown to their departed relative. We looked at local online announcement sections of newspapers and saw that staff and management had been thanked by previous families for looking after their departed relatives while they lived at the service.

The environment was very warm and welcoming, with people receiving visitors at any time and having space to talk with each other. We saw people chatting with relatives or staff or amongst themselves in dining and lounges areas which encouraged communication throughout. The service was decorated in a way that felt homely, with items that you might expect to find in the private accommodation of some people before they moved in. For example, book cases with novels and other reading material to borrow, cut flowers, clocks, pictures and bowls of fruit. One relative told us, "This place is like a home from home." Most people had decorated their bedrooms with personal items that were special to them, including family photographs, ornaments and other keepsakes. One person told us, "With all my bits and pieces, it feels more like home and I feel comfortable knowing they are there to look at. Staff help to dust them and they are very careful not to break anything."

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles, although one person told us that they received communion once a month in the service from a Church of England vicar who came to the home to provide this. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

During a trip organised on the last day of the inspection, we noted that people were suitably clothed. It was a warm day and people were suitably dressed to ensure they did not overheat, but also had additional layers in case of inclement weather. Staff who were not accompanying the trip came out to wave the people

off, which was appreciated.

Kitchen staff cared that people had a variety of foods available and did not feel "left out" as one staff member put it. We spoke with the chef about one person who was allergic to caffeine, as Tiramisu (coffee [caffeine] based Italian dessert) was being served after the main meal at lunch. They told us they had used caffeine free ingredients to ensure that they could have some. This showed that staff were thoughtful and wanted to provide alternatives to food in cases where allergies meant people would not normally be able to have them.

Good

Is the service responsive?

Our findings

We observed that staff took time to talk with visiting relatives, giving them updates about the care of their family members. A relative, who lived out of the area, told us they often telephoned the home between visits. They said, "I always get a full report from the staff. I know they take care of [family member] and that they're very well looked after." A relative also commented positively about how staff had prompted the GP to carry out a review of their family member's medicines. This had led to a change in the amount of medicines they were previously prescribed, which the relative felt had been beneficial to the person's wellbeing.

People's needs had been assessed before they came to reside at the service. The registered manager normally carried this task out and included full details of the type of support the person would need and their preferences. The assessment was carried out to ensure that the service could meet the needs of the particular person.

Detailed and personalised care plans were in place which addressed all identified needs. These included support with personal care; diet; senses and communication; mobility; oral health; foot care; personal safety; continence; mental state and cognition; social interests; and family involvement. We saw that care plans recorded how the individual preferred their care to be given and what they could do for themselves. For example, one person's care plan for oral health explained to staff what they should do and how the person liked a particular way of cleaning their teeth. Another person's plans indicated those areas of personal care they were able to do independently. Reviews of people's care records took place regularly with their keyworker and also a full yearly review was undertaken. People told us that they were fully involved with this process and those who needed additional support had family/friend involvement with other healthcare professionals as required. One person told us, "My son is involved."

The registered manager was in the process of implementing new paperwork in the service and we saw examples of this. Staff were being asked to feedback any comments on the new paperwork. The deputy manager told us that they were planning to pass over comments to the registered manager with regards to the new paperwork and how the staff had found them in terms of daily use. We noted that the explanation of how the risk rating was calculated on the nutritional assessment needed more detail and the deputy said she agreed and was already going to pass this on to the provider.

Transition to hospital records were in place which recorded pertinent information about individuals which would prove beneficial to any healthcare professional involved in the person's care. This record also detailed medicines which the person was prescribed. We spoke with the deputy manager about this and after our discussion they agreed that it would be beneficial to attach a copy of the person's current medicines administration record (MAR) to the form to ensure that the most update information was passed on and would save time.

One person's needs had increased since they had returned from hospital. Their records had been updated and the service had sourced a specialised bed for them to use to ensure they were comfortable. During the

second day of the inspection, a GP had been called out to see the person to ensure their needs continued to be met and no further actions were required.

We saw that a range of activities were organised within and outside of the service. On day two of the inspection, an outing had been planned to take out a number of people to Buxton Pavilion. The registered manager had organised the trip and was part of the staff team that escorted the group. A mini bus arrived which was sourced through a local charity and had easy access for wheelchair users and those with limited mobility. We watched people as they boarded the bus and waved goodbye as they departed. We observed that people were upbeat and smiling and one person told us, "Looking forward to it."

We also saw pictures of people who had participated in various garden and indoor parties, including one for the Queen's 90th Birthday and another for Burn's night, which had included a piper in full dress. People told us that various entertainment was in place within the service, including a pianist and visitors who came to do 'talks'.

Local schools were involved with the service and children at one school were involved with completing their Duke of Edinburgh award and visited the service as part of that. We were told that the service has a number of volunteers that came to 'chat' with people. One person told us, "Yes, I believe there was someone came to have a chat with me a little while ago, nice girl."

There was a large well established garden surrounding the building. The provider had installed raised beds so that people, if they wished, could partake in various gardening activities. There was a greenhouse which had a number of what looked like 'tomato' plants growing in them. The raised beds and borders had a range of plants and vegetables planted, including cabbages and a variety of herbs. One person told us in a joking manner, "They have planted some nice things in the garden, but see them [as they pointed to three rabbits grazing in the garden], they will have them if they [staff] are not careful!"

People told us they could make choices. For example, how they spent their time during the day or what they had to eat or what time they went to bed. One person told us, "I like to get up early, but not always!" Another person confirmed they enjoyed listening to music and entertainment when it was available at the service and said, "Sing-alongs, those are my favourite to listen to. Not keen on jazz, although it's not too bad."

We saw many compliments and thank you letters and cards had been received which praised the management and staff for their care and compassion. The registered manager confirmed that they were now starting to put a date on these to confirm when they were received.

People and their relatives told us they knew how to complain and would if they needed to. Complaints procedures were available within the home and on display for people or visitors to use should they need to. One person told us, "As things are, don't think I could complain." There was one complaint recorded. When we spoke to the registered manager about this, they told us, "We rarely have any, but if we do, we take them very seriously." We saw that the provider had provided written responses to the complainant and the matter had been dealt with in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place who also was one of the owners of the service. They were on holiday on the first day of the site visit although the deputy manager, facilities administration manager and director supported us throughout the inspection. The registered manager was available for part of the second day of our inspection and we were able to clarify some details and also provide them with feedback. The registered manager had a nursing background, although they did not practise as a nurse now. They had owned the service with their partner for over 15 years and in 2015 had celebrated 30 years of the home being a care facility for older people with the previous owners.

During our checks on staffing training and competency checks, we noted that competency checks were not always recorded on staff records or elsewhere. The Registered manager confirmed that they would ensure that where work had been completed, for example, medicines competencies, that this would be recorded in the future. We also noted that training was not always up to date.

Staff told us they were asked to read and sign policies by the provider as they change or are updated. We saw copies of policies where staff had signed to confirm their understanding and to say they had read them. This meant that staff were given opportunities to keep abreast of procedures which were updated in line with best practice. We noted however, that the induction training policy needed to be updated after our discussion with the director, administration and facilities manager and registered manager regarding the Care Certificate. We were told that this would be updated. We also noted that a number of other policies were in need of update due to the changes in the Care Act and subsequent changes to Regulations and the provider confirmed all policies would be updated.

A quality assurance system was in place and included, for example, checks on infection control, food monitoring, medicines audits, facilities audits and temperature checks. Medicines audits included checks on medicines administration records and where issues had been identified, there were actions in place. For example, it was noted to remind staff to complete reasons for disposal of medicines and staff confirmed this had been done. We noted, however, that the system had not recognised that updates were required in some of the policy documentation.

We saw that other issues had been noted in quality assurance checks, and actions were set for staff to complete. For example, on a recent infection control audit we saw that an action had been made to put in place a cleaning programme for the decontamination of curtains.

The provider had a system in place to monitor the call system which people used to summon help. There was a print out available of timings of calls and whether it was a 'call' or an 'emergency'. The provider told us that this was used to identify particular 'busy' times and also used to identify which rooms used the emergency call and how long it took for staff to respond. We noted that all of the response times were within seconds of being activated and all of the times of calls varied with no particular pattern.

Many new processes had or were being introduced at the service to ensure that the service continued to

provide good quality care to the people who lived there. For example, a new accident recording system had been introduced to capture more detail about the incident and the outcome for each person. This had been further updated to include hospital admission information.

Management meetings had taken place at the service. A recent meeting had included discussions around staffing, appraisals and forthcoming celebrations and other day to day matters arising at the service. The chef at the service confirmed that they attended regular meetings, where they received feedback on the meals provided, both from people living at the service and staff. The chef told us that meals were now provided for staff at a minimal cost each day if they wanted. One staff member said, "It's something that has just started. It's only a £1 which is nothing for what you get really. It's good." Care staff meetings had taken place, including with night staff. These had included topics such as completion of the accident book, people's dietary requirements and 'patient' focus and in a recent meeting staff discussed appointing staff 'champions' in particular areas of care, for example dementia. A staff 'champion' is a member of staff who is given additional responsibilities of ensuring that best practice is followed. Further meeting were to be held in August with regular meetings after that.

Surveys were sent and gathered from relatives, healthcare professionals and other visitors to the service, including entertainers. Questions asked included, "How prepared for your arrival were staff?" and "Do staff appear to know what they are doing?" Responses received were all positive. We also saw questionnaires to new 'residents', which included questions, "Were you given enough time to move in?" and "Did you feel your needs were understood when you moved in?" Again, responses were positive. People completed yearly surveys which enabled them the chance to feed back into the service and have any comments acted upon.

Staff surveys had been recently sent out, but only one response had been received back. Questions included, "Are you confident we provide service users compassionate care?" and "Is there enough staff?" The staff member had agreed that the service did provide compassionate care and enough staff.

We researched local websites and found the providers of Southfield House sponsored Woodford Community Council Website. This is a local on line resource for people in the area with information on neighbourhood policing, events in the area and other local information about attraction, wildlife and has a neighbourhood forum. This meant that the provider worked in partnership to support the local area and community in which they were situated.

The registration document was on display and the provider also had displayed the previous CQC inspection report, both within the service and had details on their website. The registered manager was aware of the requirements to publish the new rated inspection details and we advised the finance and administration manager how to obtain the paperwork from our 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	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not always ensured that staff had received updated training. Regulations 18 (1)(2)(a)(b)