# Southfields
# Care Home Service

Southfield House Care Services Ltd
Slamannan
Falkirk
FK1 3BB

Telephone: 01324 851336

**Type of inspection:**
Unannounced

**Completed on:**
4 June 2019

**Service provided by:**
Swanton Care and Community (Southfield House Care Services) Limited

**Service provider number:**
SP2003003257

**Service no:**
CS2003055991

## About the service

Southfields care home is registered for up to 17 people aged between 16 and 35 years of age who have a learning disability. The service is provided by Swanton Care and Community (Southfields House Care Services) Limited. The service was registered with the Care Inspectorate on 1 April 2011.

The service is provided in three separate houses on the site. Southfields House is registered for nine people and Strathallan is registered for five people. The Beeches was being upgraded during the inspection and will provide accommodation for two people.

Southfields is situated in a rural location near the village of Slamannan near Falkirk. Southfields sits in extensive grounds that can be enjoyed by service users. The service has its own transport to enable service users to access the community and public transport links are available in Slamannan.

Southfields House is a large, older property that provides spacious accommodation for service users. The house has been undergoing refurbishment and most bedrooms now provide ensuite facilities. Strathallan is a newer style, spacious bungalow. All bedrooms in Strathallan offer ensuite facilities.

## What people told us

We distributed six care standards questionnaires to service users and their relatives as part of the inspection. We received two completed questionnaires.

We spoke with a further two relatives and two service users during the inspection. People's view about the service were mixed. Service users told us it was "ok" living at Southfields but they did not always get on with the people they lived with. One person told us their staff were really good.

A relative told us new staff had been a positive influence on their family member's life.

Family members told us communication with the service was not always positive. They had asked numerous times for more regular communication using different formats but this had not happened.

One relative told us they were not sure if their family member was asked for input into their care plan and the information in the care plan was not always accurate. Staff consistency was identified as an issue that impacted on outcomes for service users.

## From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

| | |
|---|---|
| How well do we support people's wellbeing? | 1 - Unsatisfactory |
| How good is our leadership? | 1 - Unsatisfactory |
| How good is our staffing? | 1 - Unsatisfactory |

| | |
|---|---|
| How good is our setting? | 1 - Unsatisfactory |
| How well is our care and support planned? | 2 - Weak |

Further details on the particular areas inspected are provided at the end of this report.

## How well do we support people's wellbeing? 1 - Unsatisfactory

We graded the care and support service users received as unsatisfactory. This was because we identified major weaknesses in critical aspects of the service which required immediate remedial action to improve experiences and outcomes for people.

We spent time with service users and staff during the inspection which took place between 20 and 22 May 2019. We saw positive, warm interactions between service users and staff and we saw service users demonstrating their affection towards the staff supporting them.

We saw the service had developed hospital passports for service users since the last inspection. Health care protocols including epilepsy protocols and eating and drinking guidelines were also now in place. This meant the care and support service users received to monitor and maintain their health and wellbeing had improved.

Adult Support and Protection concerns were not being reported to the Care Inspectorate or other relevant agencies in a timely manner. We also noted that not all Adult Support and Protection concerns were recognised by managers and staff. Furthermore staff did not have a clear understanding of their responsibilities under Adult Support and Protection legislation. This meant service users were at risk of harm.

Restraint and physical intervention techniques were not being used appropriately or being used only as a last resort. We found there was a lack of appropriate recording of the use of physical intervention techniques. For example, we would expect to find information detailing the length of time physical intervention techniques were used, the behaviours displayed by service users prior to the use of physical intervention and the de-escalation techniques used by staff to avoid the use of physical intervention techniques. We heard low-level physical intervention techniques were being used without agreement from the multi disciplinary team and consent from welfare guardians. We concluded that staff did not appreciate the interventions they were using were forms of restraint and staff we spoke with had no knowledge or access to the Mental Welfare Commission's Good Practice Guidance "Rights, Risk and Limits to Freedom".

On examining incident reports, we found not all relevant incidents were being reported to the Care Inspectorate in a consistent or timely manner. This included reporting incidences of the use of physical intervention techniques and we noted that incident reports contained descriptions of restraint that did not correspond with the agreed techniques in service users personal plans. Staff lacked insight into the emotional and psychological impact of restraint of service users.

Service users' opportunities to exercise choice and control over their lives were restricted. Service users could not access all areas of their home freely as some doors were kept locked. For example, the kitchen door was kept locked. This meant service users could not access food and drink without demonstrating to staff that they were hungry or thirsty. This also impacted on service users' dignity. The deputy manager told us doors were locked to ensure the safety of service users, however all service users were supported on a one to one basis. We found the

service was risk averse, meaning service users' choices were limited to what the service saw as safe or achievable. This affected service users' opportunities to develop new skills and abilities and increase their independence in areas including managing their money or medication.

We did not see staff using Makaton or any other communication tools or approaches during the inspection. We determined that staff did not understand service users' communication needs. This reduced people's ability to communicate their needs, choices or decisions. We concluded this contributed to the stress and distress experienced by service users and consequently the behaviours of concern we witnessed.

Staff supported service users to access social and leisure activities in the community however we found the range of opportunities was limited. Service users' activity planners demonstrated that they engaged in the same activities each week. People were only able to get out in the community if one of the service's vehicles was available. This meant people could not always go out when they wanted to.

There was a lack of sensory equipment or sensory led activities during the inspection and we could not find information about service users' sensory needs in their personal plans. The support offered for service users lacked structure, routine and consistency which was required, particularly for those service users diagnosed as having an autism spectrum disorder. We saw service users wandering around the home with no purposeful or meaningful activities. We observed a lack of engagement between staff and service users on occasion. We concluded there was a lack of appropriate stimulation for service users.

During the inspection we witnessed service users displaying anxiety and distressed reactions and, at times, behaviours of concern. Staff told us some service users feared being hit by fellow service users. This affected service users' sense of safety and quality of life.

Whilst we were confident that service users' physical health care needs were appropriately addressed, referrals to health professionals in relation to service users' communication, emotional and psychological needs were not being made and we found the need for the referrals was not recognised by staff or members of the management team. Service users were not being supported to express their sexuality and we could not find any evidence that service users were taking part in national health prevention screening programmes.

Service user meetings were taking place in Strathallan. These focused on making choices and decisions regarding food and activities. We found people were involved in the running of their home. However service users in Southfields House did not have opportunities to participate in decision making about their home. We noted people were not supported to access independent advocacy services.

We concluded that service users were experiencing significantly poor outcomes as a result of using the service. The inspection highlighted critical weaknesses in aspects of the service which could significantly affect the care that people received. The service must take urgent action to improve the quality of care provided in order to ensure that people are protected and that their wellbeing improves without delay. We have decided to take formal enforcement action against the provider and have issued an improvement notice to the provider to address these issues.

## How good is our leadership? 1 - Unsatisfactory

We found there was a lack of leadership and support available to support staff and guide their practice. We found the deputy managers who were in the home during the inspection were rarely visible outside their office and team leaders who were on shift were supporting service users. This meant there was a lack of support and mentorship to enable staff to translate learning into practice.

The management team in the home had all been recently appointed, however some had limited management experience. Team leaders told us they had not completed an induction into their role and the deputy managers said they did not have a job description.

We found the lack of experience effected the competence of decision making by members of the management team. We heard a member of the management team discussing a service user in a negative manner. The staff member lacked understanding that the behaviour displayed by the service user was a communication of their distress.

We raised concern about the practice of members of staff with managers. Their limited response did not show they had a clear understanding of their responsibilities to take appropriate action to safeguard the health, safety and wellbeing of service users.

Staff told us they were assaulted by service users on a regular basis. Some staff told us they felt scared and anxious coming to work and did not feel safe. Staff said they came to work expecting to be hit. Debrief meetings did not take place post incident so there was a lack of opportunities to identify triggers and appropriate responses and opportunities for staff to reflect and learn from their practice. Staff said they did not feel supported. We were worried this would effect staff's abilities to recognise and appropriately respond to anxious and distressed behaviours displayed by service users.

Staff told us they were working up to 12 hours on shift without a break. Given the complex needs of the service users, we concluded staff would not be able to maintain the necessary levels of concentration to anticipate and appropriately respond to service users' needs. This also increased the risk that staff would not recognise or appropriately respond to distressed and anxious behaviour.

We found the service was not using any quality assurance systems. Audits of key systems and processes were not being carried out and there was a lack of management oversight of the service. This meant areas for improvement were not identified or addressed.

We found incident and accident reports were not reviewed or analysed to identify trends or patterns and no action was taken to reduce the risk of similar incidents or accidents recurring. This increased the risk of harm to service users and staff.

Medication audits were not being carried out. When discrepancies in stocks of medication were found, the service did not carry out investigations or implement systems to reduce the risk of recurrences. We were not confident service users were receiving their medication as prescribed. This meant people's health and wellbeing was at risk.

The Health and Social Care Standards state that service users should benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes however, we found the service had no formal systems in place to seek feedback about the service. Families were not asked how the service could be improved. Communication with family members focused on service user support rather than service improvement or assuring and improving the quality of the service. The service had not developed an improvement plan.

We found no fire drills had been recorded for 18 months and records had not been updated to reflect when service users had changed rooms. Furthermore the fire risk assessment for the service was out of date. We liaised with the Scottish Fire and Rescue Service regarding our findings.

We saw that there were major weakness in aspects of the service's management and this had a significant negative impact on the quality of service people received. Action should be taken as a matter of urgency by the service to ensure that people receive safe, appropriate and responsive care and support. We have decided to take formal enforcement action against the provider and have issued an improvement notice to the provider to address these issues.

## How good is our staff team? 1 - Unsatisfactory

We found staff were enthusiastic and wanted to support service users to experience good outcomes, however there was a lack of support, mentorship and guidance to enable staff to put learning into practice.
This contributed to major weaknesses in critical aspects of performance which led to service users experiencing significantly poor outcomes.

We heard person centred, positive behavioural support training had taken place and staff training sessions were focusing on service users' personal plans. However despite having undertaken this training, we found that staff were not able to demonstrate their knowledge, skills or understanding.

During the inspection we saw team leaders were supporting service users. Team leaders were also responsible for administering medication and on one occasion the team leader was also cooking lunch for service users. Team leaders told us they did not have office time very often and felt frustrated that they were not able to support and mentor staff.

We determined staff often did not recognise and appropriately respond to behaviours of concern displayed by service users. Staff did not recognise stress or distress being displayed by service users at an early stage. This increased the likelihood that behaviours of concern would escalate and an incident would take place and put other service users and staff at risk.

Staff were not able to predict or anticipate the likelihood of behaviours of concern occurring despite their experience of previous similar incidents. This meant incidents continued to occur. We spent time with service users and staff and noted staff lacked awareness of how to ensure their own safety when service users displayed signs of anxiety or agitation.

Staff did not identify early signs and symptoms of anxiety or act to reduce the distress experienced by the service users. During the inspection we witnessed a service user display anxiety and distress in response to being in a busy, noisy environment. Staff told us the service user regularly displayed behaviours of concern in this type of environment but no action was taken to address this issue.

Staff lacked insight into the impact of their communication and behaviour upon service users. We heard staff communicating with service users using long and complex sentences and we concluded that staff lacked an awareness of service users' levels of understanding of language. We also received conflicting information from different members of staff about service users' communication needs.

We saw supervision was taking place however there was a lack of opportunity for staff to reflect on and learn from their practice.

We found team meetings were taking place on a regular basis however meetings were poorly attended and there was no evidence to suggest those staff who had not attended the meeting had read the minutes. We were disappointed to find the staff we spoke with had no knowledge of the Health and Social Care Standards or best practice guidance.

We saw that there were major weakness in aspects of the service's staffing and this had a contributed significantly to the poor outcomes experienced by service users. Action should be taken as a matter of urgency by the service to ensure that people receive safe, appropriate and responsive care and support. We have decided to take formal enforcement action against the provider and have issued an improvement notice to the provider to address these issues.

## How good is our setting? 1 - Unsatisfactory

We saw service users had spacious, ensuite bedrooms which had been personalised to their individual tastes. However communal areas were impersonal and did not reflect the personalities, ages or interests of service users.

We found the setting did not reflect or support the needs of the people living in the home who had been diagnosed as having an autism spectrum disorder. Throughout the duration of the inspection we saw curtains hanging off the curtain rail in the dining room. This was further compounded when we found stained and scorched tea towels and oven gloves in the kitchen. Kitchen cupboards were also dirty. This made the environment appear uncared for and indicated a lack of respect for people's home.

A member of the management team told us a service user should eat their meals in the dining room even when we pointed out this did not meet the needs of the person. This demonstrated an institutional and outdated approach to care home provision. Residents should have the opportunity to make choices about how they use the space in their home.

We found the setting did not promote the independence of the young people living in the care home.

The Health and Social Care Standards state that people should be able to independently access the parts of the premises they use and the environment should be designed to promote this. Unfortunately, we found service users could not freely access food and drink because the kitchen was kept locked. When we discussed this with members of the management team we heard this was to ensure the safety of service users, however people living in the home have one to one support. We considered this restricted people's movements, curtailed their choices and increased their dependence on staff.

Office doors were kept locked when members of staff were inside. During the inspection we witnessed this area became a bottle neck when three service users wanted to access the office at the same time. We were aware from incident reports that encouraging service users to leave the office was a challenge. We concluded that service users were at risk of harm when physical intervention was used in this area as the corridor was narrow and dark.

We found the location of the setting and access to transport links made it difficult for service users to access the local community and amenities. We noted service users were not always able to access the community due to the lack of availability of the service's vehicles. The home was situated in a rural area with public transport links available a mile away in the village of Slamannan.

The home had large gardens which were not used to their full potential and opportunities to enjoy meaningful and purposeful activities in the outside space were limited. We noted a level access trampoline had recently been fitted in the garden but we expected a range of occupational and leisure opportunities to be available in the outdoor space.

The inspection highlighted critical weaknesses in the setting which could significantly affect outcomes for service users. The service must take urgent action to improve the quality of the setting in order to ensure service users are protected and their wellbeing improves without delay. We have decided to take formal enforcement action against the provider and have issued an improvement notice to the provider to address these issues.

## How well is our care and support planned? 2 - Weak

We graded this quality indicator as weak. This meant that whilst we identified strengths they were outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affected people's experiences or outcomes.

We were pleased to find an improvement in the content and quality of service users' personal plans. The provider had commissioned an external consultant to review and redevelop the personal plans. Staff told us they had worked with the consultant to provide information. Parents, guardians and members of the multi disciplinary team also provided input into personal plans. However only 50% of service users' personal plans had been completed since the last inspection. Despite the improvements in the personal plans, we found this had not led to an improvement in the standard of care and support being provided for service users.

We found service users and their families were not supported to agree outcomes or goals to enhance people's quality of life or increase their independence. We would expect service users to have the opportunity to take part in person centred planning to identify short and long term goals.

Risk assessments were based upon ensuring the safety of service users. We discussed the need to support positive risk taking to support people to increase their skills, independence and self esteem.

The Health and Social Care Standards state that service users' views should be sought and their choices respected, including when they have reduced capacity to fully make their own decisions. We found personal plans were developed in a written format only. We could not find any evidence that service users' views had been sought regarding their care and support or personal plan. A narrow range of communication tools and approaches was being used in the service which meant opportunities for service users to express their needs, choices or views were severely limited.

We found relevant information from other sources, including schools and previous service providers, was not incorporated into service users' care plans. Information regarding a service user's communication needs, support strategies and positive behaviour plans had not been transferred into their personal plan almost a year after they had moved into the home. This had a significant detrimental impact on outcomes for the person. Staff did not have a consistent understanding of the service user's communication support needs.

Inaccurate information was recorded in a service user's personal plan regarding the use of physical intervention techniques. We discussed with the deputy managers that this put the service user at risk of being restrained without the agreement or consent of relevant people and agencies.

Service reviews were taking place and we noted that members of the multi disciplinary team were invited to attend the reviews. Unfortunately, there was often little representation from stakeholders.

We found service users were not involved in their reviews. Service users should be supported to express their views, choices and decisions but we could not find evidence that support from advocacy services had been sought.

## Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

## Detailed evaluations

| How well do we support people's wellbeing? | 1 - Unsatisfactory |
|---|---|
| 1.1 People experience compassion, dignity and respect | 1 - Unsatisfactory |
| 1.2 People get the most out of life | 1 - Unsatisfactory |
| 1.3 People's health benefits from their care and support | 2 - Weak |

| How good is our leadership? | 1 - Unsatisfactory |
|---|---|
| 2.2 Quality assurance and improvement is led well | 1 - Unsatisfactory |

| How good is our staff team? | 1 - Unsatisfactory |
|---|---|
| 3.3 Staffing levels and mix meet people's needs, with staff working well together | 1 - Unsatisfactory |

| How good is our setting? | 1 - Unsatisfactory |
|---|---|
| 4.2 The setting promotes and enables people's independence | 1 - Unsatisfactory |

| How well is our care and support planned? | 2 - Weak |
|---|---|
| 5.1 Assessment and care planning reflects people's planning needs and wishes | 2 - Weak |

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### Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

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