Southwinds Limited

Southwinds

Inspection report

17 Chase Road
Burntwood
Staffordshire
WS7 0DS

Tel: 01543672552

Date of inspection visit:
24 October 2017

Date of publication:
12 December 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

This inspection was unannounced and took place on 24 October 2017. The service is registered to provide accommodation and support for up to 25 people. At the time of our inspection, 12 people with learning disabilities were using the service.

At our last comprehensive inspection on 4 May 2017, the provider continued to be in special measures following a second inadequate rating. The overall rating for this service remains inadequate, and therefore remains in special measures. This inspection found that there were not enough improvements to take the provider out of special measures. CQC is pursuing the appropriate regulatory response.

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 timescale.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was 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.

At our last comprehensive inspection in May 2017, the provider was in breach of eight Regulations. Risks to people had not been assessed, monitored or reviewed; incidents were not reported as potential safeguarding concerns; the provider had not followed guidance when people were unable to make decisions for themselves; people's independence was not promoted; and people still did not receive care that was individual to them. In addition, the provider still did not have effective systems in place to ensure they met the standards required in the home. The provider had not met the requirements needed when

things had gone wrong, and did not display their rating on the web site that was in place at the time.

We took enforcement action against the provider. On 7 August 2017, the provider informed the local authority that an action plan had been completed and submitted to the CQC. We had not received this. We asked the provider to send this to us, which they did on 11 August 2017. We saw that this action plan did not address two of the breaches in Regulations. We had also found that improvements were needed to ensure that people's choices were listened to and that they were actively involved in making decisions about their care. At this inspection, we found that the actions had not been completed, and the provider had not made the improvements they were told to.

Risks to people were still not effectively managed, and the provider had not taken the action they told us they would. Staff did not follow guidance when available to ensure that risks to people were minimised. The provider was still not reporting potential safeguarding issues to the necessary people. They had not reviewed staffing levels when people's needs had changed. There were not enough staff available to ensure people received the support they needed to keep them safe and meet their needs.

The provider was still not following the guidance available when people were unable to make certain decisions for themselves. Some people were at risk of not having their nutritional needs met, and the provider had not acted upon concerns. Some people were trying to be more independent, but the provider did not ensure they had the support they needed to do this safely and in the right way. People were not supported to make choices about their care, and their dignity and privacy was not respected.

People were not in control of their lives, and they did not receive care that was individual to them. When people had identified things they would like to achieve, they had not been supported to do this. People's care records did not reflect their needs and did not give staff important information to help them support people in the right way.

The provider did not assess, monitor and drive improvement in the quality and safety of the service. They did not respond as needed when things had gone wrong, and was still not meeting the requirements regarding displaying their latest rating. They were not able to show that they understood their responsibilities of their registration with us.

Concerns about people's changing healthcare needs were not shared with all the necessary external professionals. Staff received training, but were not always able to show how they put this learning into practice.

People received their medicines as prescribed. They were able to maintain relationships with people they knew that were important to them. Staff spoke with people in a kind manner and relatives had the opportunity to attend meetings with the provider.

We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people were not assessed, monitored or reviewed. Staff did not always have guidance to follow to minimise potential risks. When guidance was available, this was not always followed. The provider did not follow guidelines and policy to ensure people were protected from harm. Staff understood their responsibilities to safeguard people, but the provider did not respond to concerns as they should have done. There were not enough staff to meet people's needs and preferences. People received their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

The provider did not follow the legal guidance available when people were not able to make decisions for themselves. They considered making decisions for people when they did not have the authority to do this. People were at risk of not having their nutritional needs met, and risks were not managed to ensure people ate and drank safely. People were not enabled to make decisions about their meals and drinks. They were supported to access healthcare services, but concerns had not been raised with all the relevant professionals.

Is the service caring?

Inadequate

The service was not caring.

When people were trying to be more independent, they did not receive the support they needed to do this in the right way. People were not enabled to make real choices about their lives. Their privacy and dignity was not always respected. People were able to maintain important relationships with people they knew, and staff spoke with people in a kind manner.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was individual to them. When they had identified goals they wanted to achieve, they were not supported to do this. People's care plans did not always include the information staff needed to provide care that was personal to people. They had the opportunity to attend meetings with a staff member, and relatives had meetings with the provider.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was aware of current guidance they should have followed, but was not able to demonstrate their understanding of this or other policies they had in place. They did not have effective systems to drive continuous improvement or mitigate possible risks for people. The provider did not meet the specific requirements required when things had gone wrong for people who used the service. They had not notified us about events they should have done and did not display their most recent rating at the home.

Southwinds

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.

Southwinds is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Southwinds provides accommodation and personal care support for people with learning disabilities. This means that the service should conform to the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

This inspection visit took place on 24 October 2017 and was unannounced. The inspection team consisted of two inspectors. We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also had feedback from the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who used the service, one relative and two community professionals. We also spoke with two members of care staff, the cook, the deputy manager and the registered manager (who is also the registered provider). Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care plans of six people to see if they were accurate and up to date. We reviewed one staff files to see how staff were recruited. We checked records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. To ensure the service was continuously monitored and reviewed, we looked at records that related to the management of the service including quality checks.

Inadequate

Is the service safe?

Our findings

At our previous inspection, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider to make improvements to ensure that potential risks to people were assessed, monitored and reviewed. At this inspection, the provider had not made the improvements we told them to make.

Risks to people were still not effectively managed. In the action plan submitted following our last inspection, the provider stated that if an incident occurred, a risk assessment would be completed and an action plan drawn up to minimise and identify any further risk. They identified that this would be in place 'immediately.' However, we saw that two people had fallen. The registered manager had not completed a risk assessment, as they told us they would on either occasion, and had not drawn up an action plan to consider how to minimise the risk of this happening again. This demonstrated that these risks were not assessed, monitored or reviewed, and that the action the provider told us they would take to keep people safe had not been completed.

Some people were at risk of developing sore skin, and there were specific recommendations from external health professionals in place to prevent this from happening. For example, one person should have used two special cushions when seated (one under and one behind them.) We saw that these recommendations were not always followed. One staff member we spoke with was only aware that they should have sat on one cushion. We also saw that their position should have been changed every two to three hours. However, there was no system in place for staff to check this happened in a timely manner. We asked a staff member how they ensured this recommendation was met, and they told us, "I'm not sure." This increased the risk for the person, and we saw they had needed intervention from healthcare professionals as they had developed a pressure area. In addition, the provider had assessed that this person was a low risk of developing sore skin, even though they had a pressure area and continued to remain at risk. We also saw there was no care plan in place that had been completed by the provider giving guidance to staff for how to manage these risks.

At our previous inspection, we had also raised concerns about some people's safety when walking. At this inspection, we continued to have the same concerns. We saw one person was still reaching out to use various items to steady themselves. We also saw within their care plan that they should have been encouraged to use the lift instead of the stairs. However, we observed them using the stairs on their own and staff had not encouraged them to use the lift, placing this person at an increased risk of falling. Some people's mobility had changed, and one staff member told us, "I have mentioned a number of times that I think they need some equipment to help them and for the staff to do this safely, but I'm told that they get better during the day." In the action plan submitted, the provider told us they would seek assistance from outside professionals to assess people's mobility needs. The deputy manager told us that they had referred one particular person for a physiotherapy assessment on 22 August 2017. This was more than three months after our previous inspection visits when we had raised concerns about their mobility. The deputy manager told us that the physiotherapist had visited the day before this inspection visit.

We saw that a variety of cleaning products were left unattended in a corridor that people had access to. We asked the registered manager about this, and they told us, "We had a delivery yesterday and have to put the items away." This presented a potential risk to people who used the service and demonstrated the provider had not followed guidelines and policy.

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

At our previous inspection, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not reported possible safeguarding incidents to the necessary people. In the action plan submitted, the registered manager stated they would 'ensure that any safeguarding concerns are assessed to ascertain if they are reportable and, if so, report within 24 hours to the appropriate authorities.' At this inspection, we found the provider had not made the necessary improvements. For example, one person had sustained unexplained bruising. The registered manager had not considered this a safeguarding concern, and had not reported this to the local authority for investigation. Staff understood their responsibilities to protect people from harm and report any concerns. One staff member told us, "We have to protect the individuals that live here. If I had any concerns, I would tell [the provider]. Like if I saw bruising that wasn't there before." However, this demonstrated that the provider did not respond to concerns as they should have done.

This demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have reported previously about our concerns regarding the staffing levels available to keep people safe and have their needs met. At this inspection, we found that staff were not always available to offer support to people when needed or enable them to do activities they enjoyed. For example, during breakfast, we saw there was one member of staff supporting seven people. This meant that people had their meal interrupted frequently, as the staff member had to move away to assist other people. The people who were trying to be independent had no support or guidance to ensure they were doing this appropriately. We observed one person pick up food they had dropped on the floor then eat it. The staff member present did not see this, as they were busy supporting another person. One person told us, "We used to go and see the lights at the arboretum; we've not done that for many years. We've not got the staff."

During the inspection, there were long periods of time when the people in one lounge did not interact with any staff. For example, over a period of one and a half hours when we completed our SOFI, we saw the only time one person had any conversation, was when they were asked if they wanted the hot option for their lunch. When they were on their own, the person appeared to be quite distracted; they would sit in a chair for a few minutes, then get up and stand looking through the door, go and sit back down again, stand up, then sit at the table. This continued throughout our observations. Their care plan stated that they liked to keep themselves busy. They were not supported to do this during our observations. We were told that one person who used the service needed more help than they had done in the past due to their changing needs. The staffing levels had remained the same as they had been previously. In the action plan the provider submitted following our previous inspection, they stated that had recruited extra staff for the night shift. We found that the staffing available at night remained the same as before. This meant the provider had not reviewed staffing levels when people's needs changed and there were not enough staff available to offer people the levels of support they needed.

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

People received their medicines as prescribed. One person told us, "I get them every day. I need help as I might forget. It's important I have my tablets." When people were given their medicines, we saw the staff member would remain with them to ensure they had been taken. Medicines were stored safely to protect people from any risks associated with them.

We have previously reported about our concerns in relation to the environment at Southwinds. At this inspection, we found the provider had made improvements, and the communal areas were now free from any lingering smells. We saw that new carpets had been fitted in one lounge/dining area.

Inadequate

Is the service effective?

Our findings

At our previous inspection, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider was not acting in accordance with the Mental Capacity Act 2005 (MCA). This Act provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and 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 and hospitals are called Deprivation of Liberty Safeguards (DoLS). At this inspection, we found that the provider had not made the necessary improvements.

In the action plan the provider submitted, they told us they would ensure that all the people who used the service would be assessed in relation to their capacity. This demonstrated their lack of understanding of the Act, where the first principle is to assume capacity. Only if there is a concern that someone does not understand the decisions they make, should their capacity be assessed. We did see that one person had been assessed in relation to three specific decisions, in line with the Act. However, there was no evidence as to why the support they had was in their best interests. The provider confirmed to us that there were other people who were not able to make certain decisions for themselves. Their capacity had not been assessed, and we saw they had been asked to sign their care plans. The provider told us that capacity assessments were being completed by other community professionals. They still did not understand that they had a responsibility to undertake this when looking at specific decisions in relation to the care and support they provided on a day-to-day basis. The provider told us that some people were able to make certain lifestyle decisions for themselves. However, the provider was considering making changes on behalf of one person, which they did not have the authority to do. This meant the provider was still not working within the principles of the Act.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that risks were managed when people were at risk of choking. At this inspection, we found the required improvements had not been made. For example, we saw in one person's care plan that they should have had a drink of thickened water to clear their throat after they had eaten. For the two meals we observed this did not happen. It was also stated that staff should have been present when the person ate or drank. We saw they were left alone at times when eating or drinking. This meant these actions placed this person at increased risk of choking, and for this person the risks were not managed to ensure they were supported in a safe way.

Some people were also at risk of not having enough to eat or drink. We saw that one person's drinks were monitored, and their recommended intake was 2000 millilitres a day. The fluid charts that were kept had not

been totalled by staff, so it was unclear to see how much fluid they had taken. When we looked at the amount of drink they had during a six day period, the total amount recorded was between 600 and 1260 millilitres, meaning this person may not have been supported in line with their recommendations. Another person had their weight monitored. We also saw that they had lost a stone in weight. No actions had been taken to investigate this weight loss. We discussed this with the registered manager who was unable to provide an explanation for this. This meant that they were at risk of not having their nutritional needs met.

Some people needed to follow specific diets due to their medical condition. At the lunchtime meal, we observed one person pour themselves orange cordial that needed diluting with water. They were not supported to do this and received no guidance from staff. We saw they half filled their cup with cordial, and then put the water in. This was potentially detrimental to their health because of their medical condition. In their health action plan, we saw a recommendation that they should have had a care plan in place immediately for diet-controlled diabetes. We saw the NHS guidance had been printed off the web site, but there was no specific care plan for this person. This meant that staff did not have guidance specific to this person to follow.

This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have previously reported that the provider needed to make improvements to enable people to be actively involved about making decisions about their meals. We saw the provider had a board displayed in the hallway that had pictures reflecting the meals that were available for the day. However, the position of this meant that a number of people would not have gone past this display. We asked how the decisions were made about what the menu for the day was. One person told us, "[Name of staff member] decides; they tell us what the meal is, then we'll find the picture to go on the board." One person told us about their favourite foods, and added, "But I've never had it here." Another person had been re-assessed by the speech and language therapist in June 2017, who had stated that they should have had a 'normal diet' but that 'high risk foods are best avoided.' Their care plan and risk assessments still had not been updated from this assessment. These stated that the person should have had a soft diet. This meant that their options and choices could still have been limited unnecessarily, as well as being potentially confusing for staff as the information was conflicting.

We have previously reported our concerns that people did not have easy access to drinks. At this inspection, we found that some improvements had been made, but further were required. We saw that people were offered a drink when they had got up in the morning. However, in one lounge/dining area, there was an empty water jug on the side board. One person picked this up and asked, "What's this?" They put it down and then walked away. There were no staff available to see if they wanted a drink or to support them. We observed that some people were encouraged to make their own drinks, but also saw that they were still influenced by the routines that had been in place for many years. One person told us, "I have a drink at 11:00am, then another at lunchtime, then another in the afternoon." We saw that people would all come into the one dining area at a specific time to have a drink, and they did not go into the kitchen to get a drink at other times. At the lunchtime meal, we saw that the choice was water or orange cordial. There were no other options available for people.

We have previously reported our concerns that the provider did not respond to people's changing health care needs in a timely manner. At our last inspection, we found that some improvements had been made. At this inspection, we saw that people had been supported to access healthcare services. However, one community professional told us, "It wasn't the provider that told me about one person's health significantly deteriorating; they may have made contact with the GP, but they didn't inform us." We heard one staff

member share their concerns about one person's overall demeanour. They said, "[Person who used the service] keeps looking like they are in a day dream." We had also observed this person spend time staring and not responding. We spoke with a community professional about this six days later; they told us they had not been made aware of this concern. This meant we could not be confident that referrals were made quickly when people's healthcare needs changed.

Even though staff told us they received training in areas such as fire safety and moving and handling, we did not see that people received care that was based on best practice and current guidelines. For example, the provider had received training in equality and diversity issues. When asked about the changes implemented following this training, they were not able to describe how this learning had been put into practice. The provider did not have effective systems in place to assess and evaluate staffs competencies to carry out their roles effectively.

Inadequate

Is the service caring?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's independence was not promoted. At this inspection, we found the provider had not made the necessary improvements.

Some of the people who used the service went into the main kitchen to prepare their breakfast, and then took it to the dining table on a tray. One person told us, "This is how we do it now." When asked how they had been supported initially to do this, they told us, "We were told we had to do it." There was no evidence to suggest how people's skills had been assessed or how any potential risks had been considered. We observed one person butter their toast, put the knife in their mouth, then return the knife to the butter to spread some more. They also did this when they put the jam on. Each time they would lick the knife, and return it to the pot. We observed other people using the same butter and jam. Another person put the whole amount of butter that was in the pot on their toast, which was meant for all four people sitting at the table.

One group of people helped themselves to their lunch from serving dishes. They had no support during this time. By the time the fourth person served their meal, there was only a small portion left. This person had lost a lot of weight. We observed people become annoyed with other people who used the service because they were doing certain tasks when it was not their turn. One person became upset with another and we heard them say, "But it's Tuesday, that's not your day to do the table. It's mine." There were no staff available in the room to support people at this time. This demonstrated that even though some people were trying to be more independent, they were not receiving the support they needed to do this in the right way.

We saw that staff offered some choices to people. For example, when some people were offered cereal or porridge for breakfast, they chose the cereal option. However, they were not then given any option about which cereal they preferred. One person was asked to fetch their drink from the kitchen. When they did not respond to this, we observed a staff member fetch them a cup of tea. They were not encouraged or prompted to do this for themselves, and did not have a choice about the drink they had. At our last inspection, we found that people's choices were based on the routines that were in place. The provider told us this was not the case and people did not have set days to have a bath for example. At this inspection, we checked to see when people were supported to have a bath or shower. We saw that apart from the people who were able to have a bath independently, other people had all been supported on one specific day each week. We saw staff put blankets over people's legs without asking them if they wanted this, and putting music on without checking if people wanted the radio on or what they wanted to listen to. This demonstrated that people were not always supported to make choices about their care.

At our inspection in December 2016, the provider had been in breach of regulations because people's dignity was not promoted. At our inspection in May 2017, we found that improvements had been made in this area. However, at this inspection, we found that these improvements had not been sustained. For example, we observed one person having their personal care needs met in front of other people who used the service while sitting at the dining room table. We again saw that some people were wearing clothes that were stained or ill fitting. One person was continually pulling their trousers up, even though they were

wearing a belt. We saw that one person took themselves to the bathroom before breakfast. When asked if they had had their wash, they replied, "Yes I'm all done." All they carried was a towel. We checked the bathroom and there was no soap, toothpaste or other toiletries they could have used to have a thorough wash. We observed a staff member enter someone's room without knocking. They opened the door, walked in and said, "It's only me." This meant that people's privacy and dignity was not respected.

These issues demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to maintain relationships with family members that were important to them. However, when speaking with people and looking at their care records, it was evident that the only people involved in some people's lives were paid carer's or other professionals. There was little evidence that people were enabled or encouraged to develop relationships with new people.

Some of the interactions we observed between staff and people who used the service were caring and we heard staff speak with people in a kind manner. For example, one staff member was seen to offer comfort to a person who used the service, and they responded by resting their head on their arm. One relative told us, "The staff are incredibly caring."

Inadequate

Is the service responsive?

Our findings

At our previous inspection, we found the provider to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not receive care and support that was individual to them or empowered them to be in control of their lives. In the action plan the provider submitted, they stated that they would seek assistance and sustainable advice in all aspects of person centred care. At this inspection, even though the provider had sought advice, we found that people continued to receive care that was not person centred.

We have reported previously that people have been living at Southwinds for a long time. If able to, they say that they are happy with their lives, and the daily routines they follow. One relative told us, "I know my relation likes routine; they like to know what is happening and when. They like to be led." However, the support people receive should be pro-active in enabling them to develop skills when they can, and experience new opportunities in their lives, no matter the extent of their disability. At this inspection, we found that the routines were still very evident. One person told us, "We have different jobs to do on certain days. I like to have things to do." We saw that people were supported to get up in the morning in the same order; and people had their personal care needs met during the night according to a schedule as opposed to when they needed support. The provider continued to show a lack of understanding in this area, even with the guidance they had received.

Staff we spoke with did not show an understanding as to how to promote choice, independence and control for people who used the service. For example, one staff member told us, "I keep this door shut because they [the people who used the service] think they can come in here before it [the breakfast] is ready. They have to wait until it is ready." Another staff member commented, "Everyone pretty much has their baths in the evening." One person told us, "We only watch the television in here at night time; it comes on for the news at 6:00pm, and then shuts down at night. We don't watch it in the day." We saw that the television was placed in the dining area, rather than in the lounge. One person told us, "If we watch the telly together we sit at the table on the dining room chairs. We don't sit in the lounge." One community professional told us, "There is still not a great deal of difference for the people who live here. The provider's idea of person centred care is very different to what health and social care would expect. You feel like you have to spoon-feed them all the time. But we're no further forward."

We saw that some people had been asked about goals they had in their lives. These were focused on daily tasks. We asked people what they would like to do, and one person told us, "I liked going to the pub. I did go on my birthday." They had not been apart from on that occasion. Another person told us that their goal was to prepare a certain meal for people. There was no plan in place to identify how or when they were going to achieve this. One relative commented, "It would be nice if they could do things like that, but would need the support to do it." We saw photographs of people preparing a snack in the kitchen, and one person told us, "I enjoyed doing that, but I didn't like what we cooked." Another person told us how they went to the local shop to fetch a newspaper with staff on a certain day of the week. When asked what would happen if they wanted to buy a newspaper on a different day, they were not able to tell us. Their care plan stated that one thing they liked to do was to read their newspaper. It did not specify that this was only on one day a week.

We saw the floor covering had been replaced in one area. We asked people how the new flooring had been chosen. One person told us, "[The provider] chose it I think; we didn't." We asked people if they had been able to vote in the elections that were earlier in the year. One person told us, "I used to vote before, but not since I've been here though." One community professional commented, "The provider doesn't see people as individuals, or as people that can express themselves; the provider decides what is best for them. I feel."

The registered manager had tried to make improvements in relation to the care planning process; however, this had not been effective. For example, people's communication had not been fully considered. We saw that one person was described as 'unable to verbally communicate,' and that they used their hands to point to things. We saw this person was able to use some Makaton signs. Makaton is a type of sign language that people with learning disabilities use to help them communicate. There was no reference in their care plan about this, and no guidance available for staff. This meant that staff did not have the information needed to help them communicate effectively with this person. We also observed one person being shown pictures which were meant to help them choose the food they wanted. Their care plan stated, 'I do not respond to photos as a way of communicating.' In addition, the care planning process did not include a sensitive discussion with people around how they choose to express their sexuality to ensure their needs could be met by the home. For example, the only reference to individual's sexuality was that they 'liked to be clean shaven,' or 'liked their hair washed.' We asked the registered manager how people were supported in relation to their cultural needs. They told us, "We don't look at people like that; they are part of the family." When prompted further they responded, "No, I don't suppose we do." This meant that people did not receive care that was personal to them.

We sat with one person and showed them their care file. We asked if they were familiar with this, and they told us, "No, never seen that before." We went through various documents in the file, and the person told us, "They [the staff] must have written it in the visitor's room." They were aware of being asked to sign the support plan document, but could not tell us how the information within this had been decided.

These issues demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service had the opportunity to attend meetings with a staff member. One person told us, "Last time we talked about the pantomime we could go to." The provider had also arranged relative's meetings so they could offer their feedback about the service. People said they would talk to the staff if they were not happy or had any concerns. There had been no complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, the provider was in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Since March 2015, the provider has been rated as 'requires improvement' or 'inadequate' in this key question. This is now our seventh inspection since March 2015, and the provider has been in breach of a number of Regulations over this time. This inspection has again found multiple breaches in Regulations, as have the previous two. Despite seeking advice and support from various organisations, the provider has failed to demonstrate how they can make and sustain the improvements required. The provider continues to show a lack of understanding as to how this should happen. People do not receive care that is safe, effective, caring, responsive and well led. Their support does not meet the fundamental standards.

The service did not conform to the values that underpin Registering the Right Support and other best practice guidance. Choice, promotion of independence and inclusion were not promoted for the people who used the service. They were not enabled to live their lives as any ordinary citizen would. The provider told us they were aware of this guidance, but could not demonstrate their understanding of what this was. The provider was still not able to demonstrate their understanding about certain policies they had put into place that they told us about in the PIR. For example in relation to equality and diversity.

The systems the provider had to monitor the quality of the service were not consistently effective. Even though improvements had been made within the environment, other audits were not used to drive improvements. Information had been gathered, but this had not been analysed to identify any trends or themes. For example, the activities people did were still just being listed, but not analysed or reflected upon; when care plans were audited, gaps in important information had not been amended to ensure these reflected people's support accurately.

The records the provider kept in relation to the people who used the service were still not up to date, and did not reflect people's needs and preferences. The provider was not able to demonstrate their understanding about the improvements that they needed to make to ensure they met the Regulations.

As the provider has been in breach of Regulations consistently, they have demonstrated they do not have effective systems in place to drive improvements within the service. In addition, they did not have processes to assess, monitor and mitigate potential risks for people. We saw that actions had not been taken when incidents had occurred, despite the provider stating they would do this within the action plan they submitted.

The above issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not followed the specific requirements they should have done when a notifiable safety incident had occurred in October 2016. The

provider told us they did not agree with this breach in Regulation, as the matter was 'still under investigation' and they did not have the relevant papers. This further demonstrated their lack of understanding about their duty of candour. We subsequently spoke with the family that this specific incident related to. They confirmed the provider had not given them an account of events, and in addition had not offered any apology.

This demonstrated a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the comprehensive inspection we carried out in December 2016, we found the provider to be in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because they had not notified us of significant events they were required to report. At our inspection in May 2017, we found that improvements had been made in this area. However, the provider was not able to sustain this improvement. At this inspection, we saw the provider had not notified us about two safeguarding concerns that they were aware of. This meant we could not be assured the provider understood their responsibilities of their registration with us.

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

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given as well as on their web site. This is so that people, visitors and those seeking information about the service can be informed of our judgments. At our previous inspection, the provider was in breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not display their rating on their web site. The provider subsequently removed the web site. At this inspection, we saw the provider was displaying their rating from the December 2016 inspection as opposed to the latest May 2017 inspection.

This was a continued breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite meeting with the provider previously and receiving action plans stating how they would meet Regulations in the future, the provider has not made the improvements required to comply with Regulations. When improvements have been made, they have not been sustained. The overall culture of the service has not changed. It remains institutional and the care is not person centred. The provider has not taken action to mitigate risks to people. This has demonstrated that the overall management of the service is not effective. We have again concluded that we do not have confidence in the provider to make the necessary improvements required for the care and safety of the people living at Southwinds.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of incidents they were required to do. Regulation 18(b)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not promote person centred care for people who used the service. Regulation 9

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users dignity and privacy were not respected. The provider did not support the autonomy and independence of people who used the service. Regulation 10(2)(a) and 10(2)(b)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the requirements of the Mental Capacity Act 2005 and

	associated code of practice. Regulation 11(1)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks for people who used the service. Regulation 12(2)(b)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate effective systems and processes to protect people from harm. Regulation 13(3)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and were not operated effectively to ensure Regulations were met. The provider did not assess, monitor and improve the quality and safety of the service provided. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(1) and 17(2)(a) and 17(2)(b)

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not meet the requirements under

duty of candour.
Regulation 20

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display their most recent rating at the home. Regulation 20A

The enforcement action we took:

NOD served to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of staff to ensure that people's needs were met. Regulation 18(1)

The enforcement action we took:

NOD served to cancel the registration