

# Hoople Ltd

# Southbank

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Southbank is a residential care home providing personal care to up to 13 younger adults and older people with a learning disability and/or autism. Southbank provides people with long-term and short-term care across three bungalows. Each bungalow has its own kitchen, dining and living area, communal bathroom and access to the communal garden. People have their own bedrooms. At the time of the inspection there were 8 people permanently living at the home, and 2 people who was staying at Southbank for a short stay.

### People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

### Right Support

Some were supported to make their own day to day decisions and choices. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

### Right Care

People's care plans and risk assessments did not always reflect their current needs to consistently promote their wellbeing. However, staff who supported people understood people's needs as they knew them well. Parts of the home required refurbishment, and furnishings needed to be replaced, to promote people's dignity and enjoyment of life. Staff understood people's individual ways of communicating.

### Right Culture

There had been changes to the leadership at the home and this had impacted the quality assurance process. The provider was taking steps to improve the governance of the home, but these improvements were not yet fully embedded. The nominated individual visited the home regularly each week, they and the management team spent time listening to people and staff's views. Visiting professionals felt there were improvements to the communication and people experienced better outcomes.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Rating at last inspection

The last rating for this service was requires improvement, (11/12 October 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made. The provider was no longer in breach of regulation 12, Safe Care and Treatment, however, we found the provider remained in

breach of regulation 17, Good Governance.

#### Why we inspected

We carried out an unannounced comprehensive inspection of this service on 11/12 October 2023. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Southbank on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

We have identified a breach in relation to the governance of the service.

Please see the action we have told the provider to take at the end of this report.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Southbank

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was carried out by 2 inspectors.

#### Service and service type

Southbank is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us.

Southbank is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the CQC to manage the service.

Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

#### Notice of inspection

This inspection was unannounced.

### What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

### During the inspection

We spoke with 3 people who used the service about their experience of the care and support provided. We spoke with 8 staff, which included the registered manager, the deputy manager, support workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from 2 visiting professionals. We reviewed aspects of 2 people's care and medicine records and documents in relation to the governance of the service.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, further improvements were required in improving record keeping.

### Assessing risk, safety monitoring and management

- At the last inspection risks to people's safety was not always monitored effectively. At this inspection we found monitoring had increased, however, these were not always tailored to people's individual associated risks. For example, some people who were independent with drinking, had their fluids monitored daily. However, where people did need their fluids monitored, records indicated there were days they had not drunk enough, however, it was not clear if records were incomplete or the person had not drunk sufficiently. We could see that staff supported people with drinks throughout the day.
- Staff who supported people were consistent and understood people's care needs and associated risks. At this inspection we found staff had better access to people's care records, however, the information contained within the records continued to be difficult to navigate to understand the full picture of how to support people in the safest way.
- External health professionals felt communication had improved, and the outcomes for people had also improved.
- At the last inspection the safety of premises and the management of food required improvement. This inspection showed there were improvements to the management of food being stored safely. The provider had ensured the premises and equipment were safe through routine checks and maintenance, However, the furniture and fixtures of the building were old and worn. A staff member told us, "It's just a sticking plaster to make it safe...there is a lot that needs to be replaced, otherwise we're looking at damp and mould issues." Staff shared an example of a specialist bath that was out of commission for over 2 months, as the part to fix this needed to be specially ordered, due to the age of the bath. Another staff member told us about the doors and windows and said, "You should come here in winter, when the curtains are blowing in the wind when the doors are shut."
- The management team were aware the premises required improvement, and was working with the provider and other agencies to put plans in place to refurbish the home to a good standard.

### Using medicines safely

- At the last inspection the provider could not be assured people received their medication as prescribed. At

this inspection we saw improvements had been made.

- People told us they received their medication as prescribed.
- We saw staff followed safe practice when administering medication. Staff checked if people needed medicine prescribed 'as required' such as pain relief, to ensure people were comfortable.
- People received their medicines in line with their prescription by staff who were trained to do so.
- The provider was following safe protocols for the receipt, storage and disposal of medicines.

#### Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Soft furnishing's, such as sofa's and armchairs were damaged, ripped or did not have cushion covers on, which meant keeping items clean would be difficult. Staff told us it was difficult to clean the furniture and we saw this was stained. The nominated individual advised that the furniture needed to be replaced.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

People were supported to have relatives and friends visit should they wish.

#### Systems and processes to safeguard people from the risk of abuse

- Systems were in place to protect people from risk of abuse.
- People told us they felt safe by the staff who supported them.
- Staff protected people from abuse and understood the providers safeguarding procedures to keep people safe from harm.
- The provider and registered manager understood their responsibilities regarding the action to take to protect people from harm and took action to protect people where required. Where safeguarding concerns had been raised, the registered manager took action to protect people.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

#### Staffing and recruitment

- There were enough staff on duty to meet people's needs and keep them safe. We saw when people



needed assistance staff responded quickly.

- Staff told us there were enough staff to keep people safe and meet people's personal care needs.
- The provider used a dependency tool to help guide them with decisions on numbers of staff needed to meet people's needs.
- Recruiting into the home had been challenging for the provider over the last few years, however the provider felt positive that staffing had improved and long term agency staff were being supported to become permanent staff members. A staff member told us, "I've worked at lots of different places, but Southbank holds a special place for me, so I'm becoming permanent."

Learning lessons when things go wrong

- The provider had systems and processes in place to identify where things had gone wrong, and had acted upon these to reduce the risk of them from happening again.
- The management team had adapted and reviewed their checks and audits to ensure these identifying care and support was being provided in line with best practice.

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection systems were either not in place or robust enough to demonstrate the service was well managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- We continued to find that where the provider's governance checks had identified areas for improvement, timescales and accountabilities for completion were not always planned in.
- Without clear timescales and accountabilities, actions remained incomplete for months. For example, since the last inspection in October 2022, we continued to find that people's care records remained difficult to navigate, were not always individual to the person, held out of date information and daily records were not always completed.
- Action to address the environment, fixture and fittings were slow, and people continued to live in an environment that did not fully promote independence, for example, one person could not go into the garden in the bungalow they lived in, as there was a step down.
- Staff felt the poor environment had a negative effect on their wellbeing, as well as the people who lived there.
- There had been, and continued to be changes of the manager of Southbank. The registered manager told us they were leaving mid-October 2023, and a new manager had been appointed, who would be starting in September so would be able to receive a full hand over before they left. The nominated individual felt confident the new manager would bring new ideas to help drive the service forward.

Governance systems had not been established to assess, monitor and improve the service provision. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which

achieves good outcomes for people; Working in partnership with others

- The nominated individual visited the home frequently to speak with staff and people about their views and opinions. Staff we spoke with felt the nominated individual was approachable and listened to them, and took action where they were able.
- The staff felt supported by the management team. We saw the registered manager interacted positively with people who lived in the home, and it was clear they knew people well.
- Staff had had the opportunity to complete a survey in 2022, however it was not evidence that the provider had fed back to staff about how this would be used to address.
- Staff meetings were taking place, but these were basic in their approach, and did not incorporate how the team would work together to drive forward the improvements that had been identified.
- The nominated individual did tell us how they were working with staff to find the right electronic system for recording people's care going forward, so that involving the staff meant that the right system could be sourced which would further help and support staff in their role.
- Visiting professionals felt there had been improvements in their working relationship with the staff who worked at the service since our last inspection. Those we spoke with felt communication and staff's knowledge of people's needs had improved.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities to be open and transparent with people. Where events had happened in the home, they had communicated with the appropriate people and external agencies.
- The provider understood their responsibilities for notifying the CQC for other events, such as deaths, serious injuries or DoLS authorisations.
- The legal requirement to display the CQC rating of the last inspection in the home was met.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Governance systems had not been established to assess, monitor and improve the service provision. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>