Wellbeing Residential Ltd

Southernwood House

Inspection report

20 Matmore Gate
Spalding
Lincolnshire
PE11 2PN

Tel: 01775760563
Website: www.wellbeingresidential.co.uk

Date of inspection visit:
10 May 2018

Date of publication:
09 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 May 2018 and was unannounced.

Southernwood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Southernwood House accommodates up to 28 people in one adapted building. It provides care for older people some of who may be living with dementia. It also provides care for younger people who need support and people who may have a physical disability. The service is also registered to provide personal care to the same groups of people living in their own houses and flats in the community. However, at the time of the inspection the provider was not proving this service to anyone.

There had been no registered manager at the home for over six months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager had deregistered on 1 November 2017. The deputy manager was running the home with support from the area manager.

This is the first inspection where the service has been rated Requires Improvement.

The provider's recruitment processes ensured that staff were safe to work with vulnerable people and for most of the time there were enough staff to meet people's needs. However, at busy times people had to wait for care. Staff received training and support which enabled them to provide safe care for people. However, at times systems in the home did not fully support safe care. For example, there were no protocols in place to support staff to administer medicines prescribed to be taken as required in a consistent manner. In addition, records of people's nutritional intake did not record their food and fluid intake in a way which would support clinicians to assess people's dietary needs.

The home had been pleasantly decorated and there were signs to support people to find their way around the home. However, more could be done to support people living with dementia to be independent and we recommend that the provider takes account of best practice in providing a dementia friendly environment. Furthermore, we found some of the furniture was old and worn and in need of replacement.

The provider had purchased a computer system to record the care that people needed. However, staff were still learning how to use the systems and we found that the care plans did not fully support people's needs. In addition, the deputy manager and area manager had not utilised audits in the system. The deputy manager was aware of these concerns and further training on the system was planned.

Despite the lack of information in the care plans staff knew people's needs well and people were happy with

the level of care they received. Risks to people while receiving care were accurately recorded and care was planned to keep people safe. When people neared the end of their lives care was planned to help them have a dignified death and they and their relatives were offered comfort and support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were asked for consent before any care was provided and were offered choices around food, clothing and where people liked to spend time. Staff respected people's privacy and dignity. People were supported to engage in a variety of activities to enhance their wellbeing.

The provider had systems in place to monitor the quality of care needed and action was taken to resolve concerns. The area manager had reviewed the care and environment and had an action plan in place to drive improvements. Complaints and incidents were reviewed and action taken to keep people safe and to reduce the risk of similar situations occurring in the future. People living at the home and their relatives had their views of the care provided considered and They were kept informed of planned changes in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were enough staff to meet people's needs but at times people had to wait for care.

Medicines were safely stored and available for people when needed. However, there was a lack of guidance available to support staff to administer tablets that were prescribed to be taken as required.

Risks to people were identified and care was planned to keep people safe.

Staff had been trained in infection control and worked in line with the provider's policy.

Staff had been trained to recognise abuse and were confident about reporting any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The home was pleasantly decorated but did not fully support people living with dementia to be independent. Shared rooms did not support people's privacy.

People were offered a choice of food. However, the recording of food and fluid intake did not accurately record what people had to eat and drink.

The provider had invested in a computer system to record the care people needed. However, more work was needed for staff to fully understand the system and gain the benefits from using the technology.

Staff had received training and support which enabled them to provide safe care.

People's rights under the Mental Capacity act (2005) were respected.

Is the service caring?

Good

The service was caring.
People were supported by staff who were kind and caring.

People were offered choices about how they lived their life. Their dignity was respected.

Information about people was kept private and secure.

Is the service responsive?

Good

The service was responsive.

Staff knew people's needs well and ensure that care was tailored to each person's needs.

People were supported to access a variety of activities.

People were supported to have a dignified death and their relative could spend as much time as they wanted with them.

Complaints were investigated and action taken to reduce the risk of similar situations arising.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had not been a registered manager in post for over six months.

People's care records did not accurately record their needs.

There were systems in place to monitor the quality of care provided and action was being taken to rectify any concerns identified.

The provider took account of the views of people living at the home and their relatives.

Southernwood House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 May 2018 and was unannounced. Our team consisted of an inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit we reviewed information that we held about the home. This included notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also 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 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 spoke with the area manager, deputy manager, the head of care, the activities coordinator, the cook and two care assistants. We also spoke with seven people living at the home and two relatives.

We looked at a range of documents and written records including five people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

The provider did not have a system for assessing how many staff were required to meet peoples needs. The deputy manager told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had considered the number of people living in the service and the care each person needed to receive. However, they had done this based on their experience and had not formally calculated the hours of care needed based on people's identified needs. Records showed that the number of staff at work each day reflected the levels identified by the deputy manager and that they had arranged cover for when staff were ill.

Most people told us that they felt the number of staff on duty supported their needs. One person told us, "I don't feel unsafe, I can tell you that. The continuity of staff is good, you see the same staff putting you to bed and getting you up in the morning. Continuity of care is very important to me." Another person told us, "They are very good here, they work hard and there always seem to be enough staff."

However, we found that that at times people had to wait for their care. One person's care records showed that they had asked staff if they could get up at 5am. However, staff had explained to them that they had to prioritise the people who used continence aids. Another person told us, "Sometimes if I need help in the night, I ring my bell and I need to wait quite a while for someone to come, sometimes up to half an hour." Audits of the call bell response time showed that the maximum time taken to answer a call bell was 22 minutes. This showed that people had to wait for staff to be available to provide care for them.

There were suitable arrangements in place to safely order, administer and dispose of people's medicines in line with national guidelines. Staff received training in administering medicines and were observed to ensure they were competent before they administered medicines. People told us that they were happy with the support they received in relation to their medicines. One person told us, "The staff always bring me my tablets. I sometimes wake up in the middle of the night with pain in my knees and the staff are very helpful, they bring me my tablets to sort it out."

Some people were prescribed medicines to be taken as required. An example of this would be a person who was prescribed pain relief to be taken occasionally when they needed it. However, there were no instructions in place to support staff to assess people's needs and to help people make a decision if medicine was needed. This was especially important for people living with dementia who may not always be able to verbally communicate their needs and who would rely on staff to identify non-verbal communication, such as body language. Although the member of staff who administered the medicines on the day we visited could tell us about people's needs there was a risk people may not receive their medicine consistently from all staff.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been

completed to ensure that staff were safe to work with people who lived at the home.

People told us they felt safe living at the home. One person told us, "I feel safe, there is always someone around and always someone to talk to." Another person told us, "I feel safe here, the carers are very helpful and friendly. I haven't been here long, and it took me a time to relax and settle to start off with. It's a new way of living, but I am okay now."

People were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise abuse so that they could take action if they were concerned that a person was at risk. Staff were aware of the provider's safeguarding policy and were confident to raise any concerns they had with the deputy manager. Staff also knew that they could contact the local authority safeguarding team directly.

Records showed that the staff and deputy manager had raised issues with safeguarding when they had any concerns about people who may be experiencing abuse. For example, concerns had been raised about the management of a person's finances and the deputy manager and local authority safeguarding team had worked together to ensure that the person's money was safely managed.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. People's pressure cushions moved around the home with them. For example, they were put in a wheelchair if the person needed one to move. This meant that people received continual support with pressure areas which reduced the risk of them developing a pressure sore. One person told us, "I have a special cushion to sit on and they always make sure it is left for me. The staff always make sure my frame is here for me, things like that make me feel safe."

We observed staff supporting a person to move using a hoist. Staff completed the move safely and continually spoke with the person explaining what they were doing so the person knew what to expect. We saw that another person in the home was concerned about them moving the person and continually tried to interrupt staff during the move. We saw that staff dealt confidently with the interruption and ensured that the move was safely completed.

People had personal evacuation plans in place so that emergency staff had a quick reference about people and they support they would need in an emergency.

People told us they were happy with the cleanliness and infection control processes in the home. One person told us, "The home is always very well kept and clean." Another person said, "They come in my room every day and do everything; vacuum and mop the floor; dust; make the bed and clean the bathroom. They always chat to me while they are cleaning and that is lovely." One person's bedroom had an offensive odour. This was because the person was unable to fully manage their continence, would remove continence aids and would refuse personal care. Appropriate care plans were in place to support this person and their room was thoroughly cleaned daily.

Staff had received training in infection control and were able to describe the actions they took to reduce the risk of cross infection. For example, they would use protective equipment such as aprons and gloves and was their hands before moving onto the next task.

The provider had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the deputy manager and the area operations manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed

to be done to help prevent a recurrence. Staff told us that they took time at staff meetings to discuss the incidents so that learning from one incident could be applied to other people 's care.

Requires Improvement

Is the service effective?

Our findings

The home was pleasantly decorated and we saw that the provider took action to maintain the standard of the environment. For example, we saw that one bedroom had torn flooring and records showed action had been taken to order replacement flooring. However, some of the furniture in bedrooms was worn and needed attention. For example, we saw one chair where the material was loose and the cushions were not supportive. In addition, we saw that shared rooms did not protect people's privacy. There was no curtain or other method of providing privacy for people while they were receiving personal care. Following the inspection, the provider told us they had discussed this with people who were in a shared room and they confirmed that they were happy with the current situation.

Some action had been taken to support people to be independent around the home. For example, there was some signage in place to help people to find their way around. However, we saw some areas of decorations did not follow best practice guidelines for people living with dementia. An example of this was that toilet doors were not painted a different colour to make them easily identifiable.

We recommend that the provider takes notice of the best practice in providing a dementia environment.

People's nutritional needs were recorded in their care plan. Where people were unable to maintain a healthy weight, we saw that they had been referred to a healthcare professional for advice. They were also offered additional supplement shakes to increase their calorie intake. People were offered a choice of hot and cold drinks throughout the day and we saw that staff took the time to support and encourage people to drink. One person told us, "The staff are always coming around and offering drinks, even to people in their rooms. They really are very good at that."

However, while staff monitored people's food intake to ensure that they were eating enough, the records did not support staff to adequately monitor people's needs. For example, they only recorded what had been eaten and did not give an indication of how much the person had eaten. Fluid intake was also inconsistently recorded so it was not always possible to be sure how much people at risk of dehydration had drunk.

Where staff identified concerns that people may not be able to eat safely they had been referred for an assessment. Where needed and advised by healthcare professionals people were offered food which was easier for them to eat.

There was a four week menu in place. Each day there was a meat, fish and vegetarian option. The menu was changed twice a year and the changes were discussed with people living at their home and families in resident's meetings. People told us they were happy with the food provided. One person told us, "There is a good variety of food. I like wholemeal bread and I always get that. You can really have what you like. They also help you with your food, I can't chew sausage skin, but I like sausage, so they always cut it off for me. There is always something on the menu that I like." Another person said, "We choose from a menu in the morning for our lunch. If I don't like either of the choices I have occasionally asked for something else, but they have to rely on what food they have in. At lunchtime they bring out a trolley with the pudding displayed,

so you can choose there and then what you would like. Teatime is nice; we have cake, yogurt and blancmange and jelly. It varies all of the time and it is good."

When people moved into the home they had their needs assessed and any risks to their care were identified. With this information the deputy manager could ensure that staff had the skills to meet people's needs and that the provider's policy and procedures supported safe care for people. We found that arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes .

The provider had invested in a computer system to record the care people needed. This had been in place for three months when we visited. There were systems in place to ensure staff had access to important information if the computer system was unavailable. When we visited the staff were still getting used to the system and had not fully utilised all the benefits of the system. For example, they had not identified how to run reports to monitor the quality of care provided. The system had best practice guidelines built into so, for example, if a person was at risk of developing pressure ulcers the system automatically generated a care plan around pressure area care.

Records showed that new care staff had received introductory training before they provided people with care. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date. A member of staff described the support they had received when they started working at the home. This had included important training for example in supporting people to move safely. In addition, they had worked alongside an experienced member of staff so they received practical training as well.

More experienced staff told us that they had access to plenty of training and were offered plenty of opportunity to refresh and update their skills so that they remained up to date with changes in legislation and best practice. Staff were supported to undertaken nationally recognised qualifications in care. Staff were given the time to raise individual concerns and to discuss their progress at regular individual meetings with their line manager. In addition, they could discuss their career development at annual appraisals where they could identify any training needed to help them advance in their role.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. People had an emergency grab sheet in the care files which included important information about them. This could be taken to hospital with them so that important information about the person was shared.

Staff at the home worked together with healthcare professionals and families to support people to access healthcare whenever needed. Records showed that the staff had identified when people were unwell and had arranged for them to see their doctor. Staff work with the local NHS to support 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. We saw that the deputy manager had completed appropriate applications for people to be assessed under the DoLS when they were concerned that people could not make a choice about if they lived at the home.

Staff had received training in the MCA. Staff knew that they should assume that everyone has the ability to make their own decisions unless there was some indication that they may be struggling. They told us that if they had any concerns they would request support from the community mental health team. Staff told us that before any decisions were made in a person's best interest they would discuss the decision with the person's family and any healthcare professional so that all options could be considered.

Good

Is the service caring?

Our findings

People's ability to communicate was recorded in their care plans and any aids people needed to communicate such as glasses and hearing aids were identified. However, there was no record of how information should be shared with people to support their ability to understand information related to their care needs.

People told us that the staff were kind, caring and treated them with respect. One person told us, "The staff here are good and very caring. They speak to you in a respectful way and in turn I am respectful back. Another person said, "The staff are very kind, they come into my room to check that I am okay. It is very good, and they are very aware of people's privacy." A third person said, "It is a nice caring place and the people make you happy. The staff are nice; they are kind and friendly." People were supported to develop friendships in the home and this was important to their wellbeing. One person told us, "I have made friends here and that is important, in fact I have been encouraged to do so. I have a friend who I sit with at lunch and that it is so nice. We sit together and have a good chat."

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. For example, people were offered choices about what they wore and what food they chose to eat. Staff told us how they supported people to make choices in their everyday lives. For example, by offering limited options so that people did not get overwhelmed with information. For example, when supporting ladies to get dressed they would ask if they would like to wear a dress or a skirt.

When care was provided, people were offered options. No action was taken without asking the person's consent and opinion. An example of this was when people were given the opportunity to wear a protective apron during mealtimes if required. The staff asked the people "Would you like to wear this to protect your clothes during mealtime?"

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Staff had received training in privacy and dignity and told us that they support people to maintain their privacy by shutting doors and curtains when providing personal care. In addition, they helped people maintain their dignity by ensuring they remained as covered as possible while receiving personal care and by encouraging people to undertake as much of their own personal care as they could manage.

People's independence was also supported as much as possible. One person told us, "I have a frame and a high seat for the toilet, these things are important as help to keep me independent and the staff make sure they are there for me."

Good

Is the service responsive?

Our findings

The care plans had been transferred to a computer system and staff were still learning how to use the system. We found that care plans did not always support people's needs. However, staff knew people's needs well and were able to give us more person-centred information about people's care needs and how they tailored the care to meet people's individual needs. People told us that the care provided was suitable for their needs.

The provider was committed to ensuring they received people into the home in a safe and planned process. Therefore no one was admitted at night when the staffing levels were lower as this would reduce the care other people received.

People told us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person told us, "I like to do my own thing, but the activities are very good. They have something on every day. The activities co-ordinator is a very pleasant lady." Another person told us, "We have singing and dancing as we all love music. We had a good game of bingo yesterday. Sometimes we go into the dining room and do arts and crafts." The home liaised with a local school and had volunteers from the school coming over to spend time with people living at the home.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. The staff worked with community nurses and palliative care nurses to support people at the end of their lives. Anticipatory medicines were arranged. These are medicines which were prescribed and in the home, should the person be in pain. This meant that healthcare professionals would be able to access the medicine quickly and so reduce the time the person was in pain. Staff told us that when people are at the end of their lives, relatives are supported to stay with them if they wanted. Staff would provide food and drink, comfort and reassurance.

There were systems in place to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. The provider had a complaints policy in place. They had investigated all complaints thoroughly and had taken action to stop the same issues occurring in the future. Information on how to raise a complaint was available in the reception area. We saw that the provider had received two complaints and had worked with people and their families to resolve the issues raised. People told us they were happy to raise concerns. One person said, "I speak to the person in charge if there is anything that is concerning me."

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager had deregistered on 1 November 2017. Two manager's had been employed since November 2017 but neither had stayed at the home.

The deputy manager was overseeing the day to day running of the home with support from the area manager and the care manager. The This meant that the provider had been without a registered manager for over six months. Relatives we spoke with told us they felt that the care provided had declined with the changes in management.

We discussed these concerns with the area manager, who was aware that the length of time the home had been without a registered manager did not support safe effective care. The area manager told us that they would become the registered manager until a new permanent manager was in post. The provider had complied with other regulatory requirements. They had ensured that their rating was on display in the home and had told us about events in the home.

People's care records had been transferred to a new computer system. However, the care records had not been completed in a way which accurately identified people's needs. For example, we saw one person's care plan noted that they did not like to take part in activities due to their lack of mobility and discomfort. Despite this information their pain assessment showed that they were not in any pain. Further on in their care plan it noted that pain management strategies were advised, but there was no record of what these strategies were and the action staff could take to keep the person more comfortable. In another example we saw that the impact of personal relationships was not recorded. There was nothing in the care plans around how situations were to be managed and how staff could ensure that people were supported with their relationships. We saw that this relationship impacted negatively on one of the people in the relationship.

There were systems in place to monitor the quality of care provided and the area manager was now visiting regularly to assess the quality of care provided and provide support to the deputy manager. The deputy manager and area manager had identified the concerns we found during our inspection. They had made plans to correct the issues identified. For example, they had arranged for extra training on the computer systems so that they and staff understood how it could be used to enhance and improve the quality of care people received.

Staff told us that they worked well as a team and were happy to provide additional support when colleagues were sick. This supported people to receive consistent care as it removed the need to rely on agency staff to cover gaps in the rota. Staff told us they felt supported by the area manager and deputy manager. They were kept up to date with changes in the home through group and individual meetings and were confident to raise any issues they identified.

We found that people who lived in the service and their relatives had been engaged and involved in making improvements. This had been achieved through sending out surveys and inviting people and their families to meetings. One person living at the home said, "Since I was admitted I have completed a survey which asked me what I thought about what it is like living here." Surveys had been completed by people living at the home and their relatives in March 2018. The survey results showed that people were happy with the care they received and no changes were needed. We saw that any changes were discussed with people. For example, the deputy manager was working on making the garden a place people wanted to spend more time in.

We found that the provider had made many arrangements that were designed to enable the service to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles. One way that they had achieved this was by purchasing a policy management system. This was a set of polices which had been developed by experts to reflect best practice guidelines. The system also provided regular updates to ensure that when guidance changed the changes were reflected in the policies.

In addition, the area manager worked with the local care association and accessed the training they provided so that they were assured that the training provided met the latest guidance. The area manager told us they maintained their knowledge by attending conferences and working with other managers in the area to keep up to date with changes needed.

We found that the service worked in partnership with other agencies to enable people to receive 'joined-up' care. For example, they worked with the local doctors when people were ill and liaised with agencies to provide palliative support at the end of people's lives.