

Wellbeing Residential Ltd

Southernwood House

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

Southernwood House is a residential care home providing personal care to 24 people aged 65 and over at the time of the inspection. The service can support up to 28 people and is in an adapted building.

The service also provides personal care to people living in their own home. Seven people were using this service at the time of inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

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

There had been improvements in the management of risks, medicines and infection control since our last inspection. However, there were still concerns that people were not fully protected from risk as care plans for people who received care in their own home did not fully identify risk. Some areas of the home needed attention to prevent the spread of infection. Recording of medicines did not fully support the safe management of medicines in the care home .

Management audits had improved and were identifying the majority of areas in the home which needed improvement.

We have recommended the provider ensures that audits reflect best practice guidance.

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.

There were enough staff to meet people's needs and staff had the skills needed to support people safely. They had received training in how to keep people safe from harm and were confident to raise concerns.

People were supported to receive visitors in line with government guidance. People were supported to give feedback about the quality of care provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement published 07 October 2021.

At this inspection we found improvements had been made However, the provider remained in breach of one regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We inspected safe and well-led as those were the areas where we found concerns. 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.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We found evidence the provider needs to make improvements. Please see the safe section this report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified a breach in relation to the safe management of medicines and infection control processes in the home at this inspection.

We have made a recommendation about the audits in the home.

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

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 ●

Southernwood House

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

The inspection was completed by an inspector and an inspection manager.

Service and service type

Southernwood House 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. Southernwood House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Southernwood House is also a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection

This inspection was unannounced.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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 four people who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager, deputy manager and two care workers. We observed care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included nine people's care records and multiple medicine records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely

At our last inspection the provider had failed to robustly assess the risks of providing care, infection control processes did not fully support people to be safe from the risk of infection and medicines were not safely managed. This was a breach of regulation 12(1) 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 12

- For people living in the care home, risk had been identified and care plans included the information needed to keep people safe. However, the care plans for people who received care in their own home lacked personalised information on risks to keep them safe. For example, one person's care plan had a diagnosis of heart problems, however, there was no information on how the diagnosis impacted on their abilities or the care they needed. There was no guidance for staff on actions to take if the condition worsened. Moving and handling training had not been completed and staff's abilities to move people safely had not been assessed. While there had been no incidents this led to an increased risk to people.
- Medicines were not always accurately recorded or regularly checked, to show people received their medicines when they should. Mistakes in the recording of medicines had not been identified or investigated. For example, we saw one person's medicine records showed that they had one more of dose a controlled medicine in stock than was in the cupboard due to an error being made when transferring figures to a new page. Handwritten records were double signed but there was no regular stock count of medicines against the medicines administration record making it more difficult to track errors. The recording of medicines used to thin bloods was unclear leading to an increased risk of error.
- Some areas of the home were not clean, and areas of the home were not maintained to a level which supported safe cleanliness and hygiene. For example, some beds which had been made, had dirty bedsheets. High level cleaning was inconsistent and there were cobwebs in places. Toilet brushes were not clean and were an infection control risk. Some areas, including the laundry were in need of action to improve infection control.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe at the home. One person who was hoisted said, "Staff know what they are doing."
- Care plans were developed immediately for people when they moved into the home. This meant staff had the information needed to provide safe care to people. Risk assessments had identified all the risks for people and care was now planned to keep people safe.
- Medicine administration records now contained pictures to enable visual identification of people and allergies were recorded. This improvement kept people safe from the risk of medicine errors.
- In an improvement from our last inspection we saw staff were wearing their masks correctly and we were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- 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

The provider was working in line with government guidance regarding unrestricted visiting. They did ask that friends and relatives just phone to let them know when they would be visiting, to ensure there were not too many visitors at the home at the same time.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to protect people from the risk of abuse and people's rights under the Mental Capacity Act (2005) were not respected. This was a breach of regulation 13(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 13.

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).

- At our last inspection we found that people did not always have DoLS in place when they were unable to make a decision to live in the care home. At this inspection we found the service was working within the principles of the MCA and where required, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
- People told us they felt safe at the home. One person told us staff treated people well.
- Staff had received training in how to keep people safe from abuse. They were aware of how to raise any concerns with the registered manager and how to escalate them to the provider if needed. Staff also knew

how to raise concerns with external agencies.

- Action had been taken when concerns were identified. The registered manager worked collaboratively with the local safeguarding authority to ensure people were safe.
- Individual incidents were recorded, analysed and action was taken to stop the person experiencing similar incidents.

Staffing and recruitment

- There were enough staff to meet people's needs. One person said, "Staff usually come quickly if I press the call bell."
- The provider had processes in place to assess people's needs and calculate how many staff were needed to care for people safely. The registered manager had completed this process on a weekly basis.
- Staff confirmed the provider had followed safe recruitment processes. All the staff we spoke with confirmed that they had not been allowed to start work until they had received a disclosure and barring service (DBS) check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Staff had also had to bring in their certificates of learning to validate any training they had told the provider they had received.

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

At our last inspection audits had failed to identify concerns and action was not being taken to improve the quality of care provided in the home. This was a breach of regulation 17(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 17.

- At this inspection the registered manager had improved the management systems in the home. Audits were in place to monitor accidents and incidents, falls, weight management and health and safety. The registered manager had completed the audits in the home and there were clear action plans in place to show the action taken to rectify any concerns found.
- However, some audits did fall short in identifying some of the concerns we found. This was because they had not included all areas of best practice within each audit. For example, the medicines audit did not cover the storage and dating of topical creams, and therefore issues in this area were not identified. While there was no impact on people, this meant the registered manager had not always been able to drive the improvement needed.

We recommend the provider review their audit system to ensure all best practice guidance relating to the provision of safe care is reflected.

- The registered manager had taken action to comply with the regulatory requirements. They had notified us about events which happened in the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- People were positive about the home and quality of care provided. People felt comfortable talking to staff or managers, if they had any concerns. One person told us, "both [registered manager] and [deputy

manager] are approachable and I trust that they would do something, but I have never had to raise any concerns." Another person said, "I can hand on my heart say I am really happy here."

- The provider understood their duty of candour. There had been no incidents reportable under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, truthful information and a written apology.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they were happy to raise concerns about their care. One person said, "If I had any concerns I would speak to the [registered] manager."
- People and their relatives were provided with opportunities to provide feedback to the registered manager on the quality of care provided. The registered manager used this feedback to improve the service.

Continuous learning and improving care; Working in partnership with others

- Incidents were recorded and monitored. Action was taken to protect individuals from repeated incidents of a similar nature. However, analysis of incidents over time was missing and so the registered manager may miss opportunities to improve the care provided.
- The manager worked collaboratively with health and social care professionals to ensure that people received care which met their needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	The provider had not ensured medicines were safely managed or that the environment supported good infection control.