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 and nursing 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
People were not supported to have maximum choice and control of their lives and whilst staff supported people in the least restrictive way possible and in their best interests; the policies and systems had not been followed.

Systems to monitor the quality and safety of the service were ineffective and had not picked up areas where improvements were needed.

Staff had not always identified where people were at risk of abuse and had not raised concerns with external agencies to get support and advice.

Risks to people were not reassessed when people's needs changed and had not been reviewed on a regular basis. This put people at increased risk of falls and malnutrition.

Medicines were not safely managed, and people could not be assured of receiving their medicines as planned. Medicines audits did not drive improvements in the quality of medicines recording.

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

Rating at last inspection
The last rating for this service was good (published 31 December 2019).

Why we inspected
We received concerns in relation to the management of medicines, infection control, staffing levels and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Southernwood House on our website at www.cqc.org.uk.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding people from harm, safe management of medicines, keeping people safe from risk and the management of the service at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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 Care Act 2014.

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 two inspectors.

Service and service type
Southernwood House 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. This service is also a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy Manager, senior care worker and chef. 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 eight people's care records and multiple medication 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.

After the inspection
We reviewed the data the provider sent us which we had requested at the inspection.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Systems and processes to safeguard people from the risk of abuse
• Staff had failed to recognise and respond to the signs of abuse. Whilst staff had received safeguarding training, they had not recognised that some people may have been at risk of being abused through neglect. One person had recurrent bruises and skin tears. There was no record of any action being taken to investigate the causes of the bruises and no changes in care had been made to keep the person safe. Following the inspection, we made safeguarding alerts for two people.
• Staff had not recognised when people may have been put at risk of abuse by other healthcare professionals. One person at the home returned from hospital without some pain relief medicines in place. No concerns were raised by the registered manager that this person had not been appropriately supported with their medicines while in hospital
• Systems in place to ensure that people's rights were protected and not been fully effective during the COVID-19 pandemic. Although five people had a Deprivation of Liberty Safeguard (DoLS) in place, nine others required applications to be submitted. This meant staff would not legally be able to stop people leaving the home when they were unable to keep themselves safe from risks. The registered manager told us they would work with the local authority to support the human rights of the people without a DoLS.

People were at risk of abuse and not having their rights protected. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They said they would ensure staff received further training in keeping people safe from abuse.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people were not properly assessed and care was not planned to keep people safe. One person was severely underweight and had not been referred to a healthcare professional for support with maintaining a healthy weight. Their weight had not been recorded in their care plan since May 2021 and there had been no assessment of their malnutrition risk since February 2020. They were meant to have their nutritional intake recorded but this was incomplete and would be unable to support an assessment of their needs.
• People's emotional needs were not risk assessed. One person living with dementia would become distressed at times. There was no care plan in place to support staff to help the person manage their distress. No assessment of the risks posed to themselves or others in the home had been completed.
• Lessons were not always learnt when incidents happened. Incidents were not fully recorded. For example, incidents of behaviour that challenged had not been recorded as incidents. When incidents had been

recorded there was no evidence that action had been taken to reduce the risk of similar incidents in the future. For example, following falls there was no review of a person's mobility care plan. There was also no analysis of falls over time to see if there were any trends which could be identified, and action taken to make care safer.

Using medicines safely
• Medicines were not safely managed in the service. Accurate records of medicines were not kept. There was no photograph identification in place for some people to help staff identify the correct person to administer the medicines to. Medicine administration records had not been fully completed and this meant it was not possible to identity if people had received their medicines as required.
• Some people had medicines prescribed to be taken as required. For example, medicine for pain relief. Protocols were not always in place to support staff to administer these medicines in a safe consistent manner.
• There was no daily record kept of how much medicine was in stock, as the amount received and administered had not been completed on the medicine administration record. In addition, records had not been kept of how much medicine had been returned to the pharmacy. This meant it was impossible to audit the medicines to ensure they supported people's needs and had been administered correctly. One medicine recorded as being available in the home had been sent with the person when they left the service.
• People told us their medicines were administered on time.

Preventing and controlling infection
• The registered manager had not ensured personal protective equipment was used effectively. When taking breaks, staff put their masks under their chins, instead of removing them and replacing them with a clean mask when they went back to work. Additionally, we saw that kitchen staff at times had their masks under their chin whilst working and the registered manager continually touched their mask. Staff who were unable to wear masks for health reasons were not supported with appropriate risk assessments. This increased the risk of infection being spread.
• The premises did not fully support good infection control processes. Some areas of the kitchen could increase the risk of infection, for example, there was limescale of the sink area and the boiler top was rust. This meant that cleaning would not be effective.
• The systems in the laundry did not ensure infection control standards were fully met. The size of the laundry meant that an effective dirty to clean flow could not be maintained.

The lack of systems in the service meant that it was not possible to assess if people received their medicines safely, if people were protected. Infection control measures were not always followed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us staff would receive further training in medicines and they would take action to get support for the people identified as at risk.

Staffing and recruitment
• There were enough staff to meet people's needs and staffing was flexible when people's needs change. People told us that staff were kind and caring.
• The registered manager used a staffing tool to identify how many staff were needed depending on people's needs. They explained that while currently they were not at full occupancy, they had not reduced the number of staff as people's needs had increased following the COVID-19 outbreak.
• Care calls were completed in a timely fashion for people who received care in their own homes.
• Safe recruitment practices were followed ensuring references were checked and a criminal records check

was completed on all staff before they started working at the home.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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
• The provider had systems in place to monitor the quality of the service provided. However, we saw they were ineffective and did not assess, monitor or improve the quality of care provided. They had failed to provide effective oversight of medicines, safeguarding and infection prevention and control. This meant staff continued to not follow best practice guidance.
• Some new staff had not received training in how to keep people safe from abuse. More established staff told us they were confident to raise concerns.
•The registered manager had not ensured systems to protect people's human rights were fully effective during the COVID-19 pandemic. Nine people, who were unable to make a decision about where they lived required a Deprivation of Liberty Safeguards application to be completed. This would ensure that any deprivation of liberty was lawful and in the person's best interest.
• Incidents were not monitored and were not always recorded. This meant any learning from incidents was lost and could not be used to improve the quality of care provided in the service.

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 told us that the registered manager and deputy manager were approachable, and they were happy to raise any concerns.
• Staff told us the registered manager was supportive. One member of staff said, "They are very supportive and try and make it work for you."
• The provider understood their duty of candour, however as incidents were not fully recorded the provider may not have all the information necessary to fulfil their legal responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Surveys had been completed to gather the views of people living at the home. However, there were no evidence of any action being taken following the surveys to improve the quality of care people received.
• The registered manager worked collaboratively with health and social care professionals to ensure that people received care which met their needs. However, concerns had not been appropriately raised to support people's well-being.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This had increased people's risk of harm and had not protected their rights. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They identified actions they needed to take to improve the oversight of the inspection.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) Systems to manage medicines were unsafe, government guidance was not followed in the use of personal protective equipment and risks to people were not effectively managed.

The enforcement action we took:

The provider is required to improve the management or medicines, infection control and risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1) People were not protected from the risk of abuse and people's rights under the Mental Capacity Act (2005) were not respected.

The enforcement action we took:

The provider is required to make improvements in their ability to manage safeguarding and to protect people's right.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The provider had not operated effective systems to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

The provider is required to improves the quality monitoring of the service