Vorg Limited

Southwoods Nursing Home

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

This focused inspection took place on 6 December 2018 and was unannounced.

We carried out this inspection in response to concerns we received about the care and support being provided to people living at Southwoods Nursing Home. Information shared with CQC raised concerns about a lack of access to hot water, poor management of accidents and incidents and unsafe moving and handling practice. The inspection looked at two of the five questions we ask about services: is the service safe? And is the service well led? This is because we needed to know if people were safe in the service; and that the identified risks associated with the information we had received had been dealt with appropriately.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At our last comprehensive inspection in February 2017 the service was rated as good.

Southwoods Nursing Home 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. The service can accommodate up to 38 older people, some of whom may require nursing care. At the time of our inspection, 33 people were supported.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Where accidents and incidents occurred, the records relating to this were not detailed and follow-up actions had not been taken to respond to and mitigate potential risks.

Safeguarding concerns had not been consistently notified to the local authority when there were concerns a person who used the service may have experienced physical harm.

The management of prescribed creams was not safe. Creams did not consistently have labels to identify who they were prescribed for and the prescribing instructions. Creams were being used that were out of date or prescribed for a different person. Records for the administration of creams were not consistently

completed and did not guide staff on the level of support the person required.

Equipment was being stored inappropriately and risks around cross contamination were poorly managed. A sling, still in use, was worn and frayed around the edges.

Fire drills had not been completed in line with the recommendations from a fire officer visit in 2017.

The premises were not safely maintained. Some people did not have access to hot water in their bedrooms and issues with the hot water system had been long standing. Legionella tests and checks of the hot and cold water temperatures had not been taken to ensure the risks around legionnaires disease had been assessed and mitigated.

The registered manager and provider did not have robust quality assurance systems to identify and address areas of practice where the quality and safety of the care and support provided had been compromised. Issues and concerns identified during the course of our inspection demonstrated ineffective quality assurance systems. Whilst the registered manager was responsive to our feedback and implemented action plans to address areas of concern, this demonstrated a reactive rather than proactive approach.

At this inspection we found the provider was in breach of four regulations: Safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment and the governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

Risk assessments were completed when there was an area of potential risk. Staffing levels were safe. Staff responded to people in a timely manner and staff were visible throughout our inspection. Checks were completed to ensure staff were safe to work with people however elements of the recruitment process required development to ensure they were sufficiently robust. People who used the service and their relatives told us they felt safe.

People who used the service and staff felt the service was well-led. People's relatives and staff told us both the registered and deputy manager were approachable and supportive. Staff meetings were held and people's feedback was sought on the running of the service.

This is the first time the service has been rated requires improvement.

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 safe.

Appropriate action following accidents and incidents had not always been taken to reduce the risk of reoccurrence.

Topical medicines, such as creams, were not stored safely. Staff had failed to appropriately record prescribing instructions.

Safeguarding processes were not followed to ensure people were protected from potential abuse.

The maintenance of the building and equipment was not always safe. Infection processes required improvement to minimise and control the spread of infection.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Effective systems were not in place to monitor and improve the quality of the service which presented a risk to people.

People's input was sought in the running of the service and staff felt supported.

Southwoods Nursing Home

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.'

We undertook a focused unannounced inspection of this service on 6 December 2018. The inspection team consisted of two inspectors.

This inspection was prompted by concerns shared with us. Concerns related to there being a lack of hot water, poor response to accidents and incidents and unsafe moving and handling practices. We used this information to plan our inspection and have reported our findings in relation to these concerns in the body of our report.

We looked at two of the five questions we ask about services: is the service safe? And is the service well led? This is because we needed to know if people were safe in the service; and that the identified risks associated with the notifications we had received had been dealt with appropriately. No concerns or significant improvements were identified in the remaining Key Questions during our inspection activity so we did not inspect them. The ratings from the last comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection

Before our inspection we reviewed information we held about the service, which included information shared with the CQC and statutory notifications sent to us since our last inspection. The provider is legally required to send notifications about events, incidents or changes that occur and which affect their service or the people who use it. We also contacted the North Yorkshire County Council commissioning team.

During the inspection we spoke with two people who used the service and three relatives. We spoke with four members of staff which included the registered manager, deputy manager, nurse and care worker. We also spoke with people as we moved around the service.

We checked the hot water supply in each person's bedroom.

We reviewed recruitment information for the most recently appointed member of staff. We looked at care records for three of the people who used the service, which included care plans, risk assessments and daily records. We reviewed the systems in place in relation to the management of medicines and accidents and incidents.

We considered a variety of documentation relating to the running of the service which included maintenance and health and safety. We also reviewed the audits completed by the registered manager and provider.

Requires Improvement

Is the service safe?

Our findings

Before our inspection, we received information detailing concerns about a lack of appropriate follow-up action following accidents or incidents and poor property maintenance, which included hot water not always being available in people's bedrooms.

We found the management and response to accidents and incidents was not adequate which had put people at risk of avoidable harm. Staff recorded when a person had been involved in an accident or incident. However, there was insufficient detail within the accident reports about how the incident occurred, actions taken to ensure the immediate safety of the person and measures taken to mitigate potential risks of this reoccurring. For example, one person had sustained a skin tear from their wheelchair footplates. The accident form completed by staff failed to identify actions that could have been taken to mitigate further risk of injury. Staff also failed to report this accident to the registered manager, in line with the provider's policy. As a result, this person suffered another skin tear from their wheelchair footplates nine days later. We also found the person's care plans and risk assessments had not been reviewed or updated following either incidents.

The use of topical medicines, such as creams and emollients, was not safe. Creams were not always labelled with the person's name or prescribing instructions. Two people had creams in their rooms which belonged to other people. We found some creams were out of date and the date of opening had not been recorded to ensure it had been used within a safe timeframe. Some external creams were stored in people's bedrooms in the same containers as people's toothbrushes and toothpaste which presented a risk of creams being ingested. Administration records for creams were not appropriately completed to demonstrate peoples' cream were applied as required. For example, one person was prescribed a cream but it was not recorded why this was required, how often it needed to be applied or where to apply it. At the time of our inspection we did not find any concerns in relation to people's skin integrity and people's skin was in good condition. This suggested staff were providing appropriate levels of support in this area, but this was not being recorded appropriately. Both the registered manager and deputy manager acknowledged our concerns about creams. They agreed to immediately address this with staff and complete a thorough review of people's creams and their storage.

There were poor infection control practices at the service, some of which presented a risk of cross contamination. This included a pillow placed on top of a person's commode in a dirty pillowcase, an inflated hair-washing bowl in a sluice room and mouth swabs, to assist people with their oral care, in opened packets next to their sinks. Parts of the laminate flooring was damaged, which would prevent this from being effectively cleaned. We found armchair covers that were stained and unclean. We also found a toilet room which was dirty and was being used to store four people's walking frames. We requested the toilet room was thoroughly cleaned and frames removed and stored appropriately. The deputy manager was present for much of our walk around the service and observed these practices. They advised staff were aware of infection control practices and agreed to address these with them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014: Safe care and Treatment

Training records showed most staff had received safeguarding training. There were 33 members of staff which included the management team, nurses and care staff. All staff had completed safeguarding training except for three recently recruited care staff. However, we found evidence that safeguarding concerns had not been raised with the local authority to enable them to undertake investigations. This included the person who had sustained skin tears and another person who had unexplained bruising to their wrists. These bruises were documented within the person's records but no follow-up actions had been taken and an incident report had not been completed. We requested safeguarding alerts were submitted for these two people.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment

Equipment, including slings and hoists, had been checked by an external company within the required timeframes to ensure these were safe to use. However, we found a sling that was worn and frayed around the edges in a person's bedroom. It was, therefore, unsafe to use and posed a potential risk of injury and should have been taken out of circulation by staff. We requested this sling was immediately removed. The deputy manager confirmed another sling was available for the person to use whilst a replacement was ordered. Other slings seen were in good condition.

A fire officer visited the service in February 2017. Their report highlighted issues which needed to be addressed to ensure the safety of people who used the service in an event of a fire. This included fire drills being undertaken with staff. These fire drills had not been undertaken at the time of our inspection. Checks were completed for some of the fire equipment within the service, including fire alarms and emergency lighting, but checks of the fire doors were not in place.

We noted oxygen cylinders were being stored in a person's bedroom, which presented a fire risk, and there was no information to identify that oxygen was in use. The sign was later found and placed on the person's door and we discussed the safe storage of oxygen cylinders with the deputy manager.

The premises were not always properly maintained to ensure people's comfort and safety. Some bedrooms had access to en-suite bathrooms whilst others had a sink in the coroner of their room. In 16 of the 28 bedrooms we checked there was no hot water and in two of the bedrooms the hot water taps did not work. Whilst we were checking the hot water a person who used the service stated, "You will be lucky to get any hot water. It has never worked since I came in." People told us staff carried warm water from the sluice room when supporting them to have a wash. A staff member advised there had been intermittent and long-standing problems with the plumbing which has resulted in problems with the hot water. The management team advised they were aware of previous issues with the hot water, which had been fixed. They advised they had not been made aware of any current issues and that maintenance checked the temperatures on a regular basis. Records of the checks of water temperatures were last completed in November 2018 which showed people had access to hot water in their bedrooms at that time.

There were broken radiator covers in some people's bedrooms and trailing wires which could be a trip hazard for the staff or the person. Wardrobes were not always secured against the wall to prevent these from falling.

Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria which can develop in water systems. Appropriate measures were not in place to control the potential risk of legionella

developing. Legionella tests had not been conducted since 2013 and temperatures, of the hot and cold water outlets, had not been taken to ensure these were within the recommended limits. Water outlets which were not in regular use were not being flushed and records for the de-scaling of equipment were not in place.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment

During the inspection we discussed our concerns with the registered manager and deputy manager who were responsive. An action plan was provided following our inspection which detailed the actions they had taken to address the shortfalls and concerns we found. The registered manager confirmed each person now had access to hot water in their bedrooms and this would continue to be monitored by the management team. The management team were now monitoring the use and storage of creams and fire drills have been scheduled. The deputy manager advised a team meeting would be arranged to discuss and learn from the points raised during our inspection with staff.

Recruitment practices were safe. A check was undertaken with the Disclosure and Barring Service (DBS). DBS checks return information from the police national database and help employers make safer recruitment decisions. Applications forms and interviews were completed with potential candidates. We noted a gap in one person's employment which had not been explored during the recruitment process. We discussed this with the deputy manager who agreed to address this with the staff member and assured us gaps would be discussed in future.

Most of the people who used the service and their relatives told us they felt safe and well cared for. One person stated, "The staff come to see me regularly. They turn me and give me drinks." A relative told us, "I know [name of relative] is safe, warm and well fed with people looking out for them." Another relative stated, "Before [person's name] was not good but here, she's improved. She thinks the staff are marvellous." We observed people were clean and comfortable. We did not observe any unsafe moving and handling practices. Staff advised they would report unsafe practices to the management team.

Staffing levels were safe. People had access to call bells and these were answered in a timely manner. Agency staff were used to ensure safe staffing levels for people. Agency profiles were in place which contained details of training and checks completed to ensure they were safe to work with people. A staff member told us the quality of agency staff was good and stated, "The agency staff we have come consistently so we have continuity for our residents."

Risk assessments were in place for areas of identified risk, which included falls and moving and handling, and were reviewed.

Service contract agreements were in place for moving and handling equipment such as hoists and slings, fire safety, electric, gas and water systems. The associated equipment was regularly serviced at appropriate intervals.

Staff had access to personal protective equipment to help control the spread of infection and wore this appropriately.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who registered with the CQC in October 2013. They were supported in their role by a deputy manager and they worked closely together. Both the registered manager and deputy manager assisted us throughout our inspection and were open and honest in their approach.

We looked at the procedures in place for quality assurance and governance. These enable registered managers and providers to monitor the quality and safety of the service and to drive improvement. We found systems in place were not effective.

The registered manager completed or delegated a series of audits. These included checks of the environment, care plans and daily records. These audits were not up to date at the time of our inspection and the registered manager was not aware of the shortfalls we found.

Staff practice within the service was not consistently safe. When accidents or incidents occurred, there was limited information about how it happened, and the actions taken in response. Staff had not consistently informed the registered manager of incidences that had occurred, in line with provider's policy. The registered manager advised they usually checked the accident and incident reports on a regular basis to ensure appropriate follow-up actions had been taken. However, this monitoring had not been conducted recently due to ongoing staffing issues which meant the management team were supporting staff in meeting people's care needs.

Safeguarding concerns had also not been raised appropriately when there was a risk people may have experienced abuse or improper treatment.

There were concerns around the storage and administration of people's creams. Audits of medicines had been completed by the registered manager and another member of the management team who has since left. Whilst these audits highlighted some issues, an action plan was not in place to demonstrate these issues were followed up. These audits had also failed to pick up the significant recording and practice issues we found.

The premises and equipment were not safe. People who used the service and staff told us issues with a lack of hot water were longstanding. The management team advised they were not aware of current issues with the hot water as they thought this had been resolved following recent maintenance works. Parts of the service were unclean and some infection control practices presented a risk of cross contamination. Fire drills had not been completed in accordance with the recommendation from a fire risk assessment in 2017. These shortfalls demonstrated that the registered manager had failed to access, monitor and improve the service.

The owner of the service visited to provide oversight. They reviewed areas such as the environment, recruitment and human resources. At their last visit, in September 2018, some issues had been noted with the environment, such as flooring which required replacing. Whilst these checks had picked up on and

addressed some points for improvement they had failed to highlight and address the numerous issues we found during this inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Confidential paperwork was not always stored securely. People's care plans, daily records and behaviour support plans were on tables within a communal lounge, which meant they were accessible to visitors or people who used the service. We discussed this with the deputy manager who advised these care plans had recently been written in, but acknowledged they should be securely stored after use. This was immediately addressed.

As the registered manager and deputy manager sometimes worked as nurses in the home this was an opportunity to maintain their knowledge of practice. They could also observe staffs' working practices and ensured the management team were visible to people who used the service. The registered manager was familiar with the needs of the people who used the service and had established a rapport with some people and their relatives.

People who used the service and their relatives provided positive feedback about the management and care people received. A relative told us, "On the whole, they are brilliant." They went on to explain how a doctor supported their relatives move to this home as they had confidence the person's needs would be met. Staff told us they felt supported by the management and one staff member stated, "[The registered manager] is always there and is supportive; their door is always open."

Staff meetings were held and information was shared about recent checks of the services or observations to improve practice.

Feedback was sought from people who used the service through residents' meetings and quality assurance surveys. The most recent quality assurance survey focused on the quality of the food and the outcome of these surveys were available to people. People were generally positive about the quality and variety of food. Residents and relatives' meetings were held although the registered manager noted low or no attendance at some of these meetings. At the most recent meeting held people shared their ideas for the summer fete. The records showed it was an opportunity for people who used the service to ask any questions.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people who used the service. Risks to people's health and safety and the mitigation of those risks were not sufficient to keep people safe from harm. This included risks around medicines management, equipment and controlling the spread of infection. Regulation 12(1)(2)(a)(b)(e)(g)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been operated effectively to ensure people were protected from the risk of abuse or improper treatment. Regulation 13 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always clean, secure or properly maintained to ensure the safety of people who used the service. (1)(a)(b)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been

established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to improve the quality and safety of the services provided. Regulation 17(1)(2)(a)(b).