Sanctuary Home Care Limited

Southwood House

Inspection report

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13 October 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 11 and 13 October 2017. Southwood House provides care for up to 14 people with physical disabilities and at the time of our inspection 11 people were living at the home

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Risks to people had not always been recognised and assessed, and historic risks to people had not always been identified in people's care plans. Accidents and incidents had not always been recorded and investigated appropriately.

There was enough staff to meet people's basic care needs; however people told us that social opportunities were limited and restricted.

Peoples concerns were not always recorded as complaints. These concerns had not been investigated and people continued to have the same concerns and felt that they were not being listened to.

The staff team did not always feel supported by the management team. The feedback we received suggested that the manager was overloaded with tasks and did not have time to complete all of the roles effectively. However, a new deputy manager had been appointed and had commenced their role on the day we inspected and staff thought this support was going to make a positive difference.

Most people told us they were treated with dignity and respect; however we also saw and were given examples of occasions where outcomes for people were not as good as they could have been.

People's health and well-being was monitored by staff and they were supported to access health professionals; however we saw that on one occasion this did not happen in a timely manner. People were supported to have sufficient amounts to eat and drink to maintain a balanced diet.

Staff received the training they required to meet the needs of the people they were caring for and the induction process for new staff was comprehensive.

Care plans contained information about peoples assessed needs and their preferences, however they required completing in more detail to enable care staff to offer a more person centred approach.

There were safe systems in place for the management of medicines; however some documents relating to medicines required updating.

All staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately.

Staff understood the importance of obtaining people's consent when supporting them with their daily living needs.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people had not always been assessed and did not always accurately reflect historic risks.

There was not always enough staff deployed to ensure people could access the community when they wanted to.

Accidents and incidents were not always appropriately recorded and monitored.

People's medicines were always appropriately managed and safe recruitment practices were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive care from staff that felt supported by the management team.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People were supported to have sufficient to eat and drink to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel that they were treated with kindness.

People were not encouraged to maintain or develop their independence.

People were supported to make choices about their care and staff respected people's preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's concerns were not always recorded as complaints and therefore were not investigated.

There was a lack of social opportunities for people.

It was not clear in people's care plans how people were supported to work towards their goals and aspirations.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The was a lack of oversight by the management team in the day to day culture of the home.

Quality assurance processes to monitor the effectiveness of the service were not sufficient.

The last inspection report rating was not displayed as required.

Southwood 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 unannounced inspection was undertaken by one inspector on 11 and 13 October 2017.

The inspection was prompted in part by the notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risk; these were risks relating to the environment, assessing known risks to people and suitably deployed staff. This inspection examined those risks.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with five people who lived at the home, two relatives, three visitors, six care staff, two shift leaders, the deputy manager and the manager. We also spoke with the regional service manager. The registered manager was on holiday at the time of the inspection.

We spent some time observing care to help us understand the experience of people who lived in the home.

We looked at care plan documentation relating to six people and two staff personnel files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People were assessed for their potential risks such as falls. People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. For example where people's mobility had deteriorated their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how to mitigate people's risks to ensure people's continued safety. For example, where a person was identified at risk of losing their balance and being unsteady on their feet there were clear instructions for staff to ensure the person was aware of any uneven flooring and to encourage the use of handrails. However, we also found that a known risk to a person had not been documented or referred to in their most up to date care plan. The registered manager had submitted a notification to the commission in the previous 18 months highlighting a risk to a person who lived at the home and this was not clear in the person's care plan. Staff we spoke with were also not aware of the risk. We discussed our concern with the manager and regional service manager and following the inspection we were provided with evidence that the risks had been assessed and appropriate follow up action had been taken.

There was a risk to people living in the home because it was not always known who was in building. There were five people who were tenants in a supported living type accommodation on the first floor of the building and these people were able to receive visitors into their accommodation and also use the dining room/lounge area of the home with their visitors where people who did require personal support chose to spend their time. It was clear in the guidelines for tenants that they were responsible for ensuring the building was secure upon their visitor arriving and leaving and they also took responsibility for ensuring the visitors adhered to the 'rules' of the home. We were concerned that there was no staff or management oversight of the visitors to the home and the risks that visitors may pose to people who were in receipt of personal care. We discussed our concerns with the manager and they offered assurances that these concerns would be addressed.

People and staff had mixed views about whether there was enough staff on duty to meet their needs. The comments we received told us that there was enough staff to meet people's basic needs and no-one felt rushed or had to wait for care to be delivered; however people and staff felt that people's social needs were not being met. One person told us "The staff always support me when I want to get up in the morning and with my shower; but I would like to go out more." Another person told us "I don't have to wait for my support and staff always come when I ring the bell; but I feel trapped in here sometimes." One staff member told us "We do what we can for the residents but people don't get the key working time that they should get and outings are limited." Another member of staff told us "We haven't got enough drivers to drive the mini bus and we don't always have enough staff on to take people where they want to go." There was enough staff to meet people's care needs but not enough to meet people's social needs.

We received continuous feedback that the home had been without a cook for the past 12 months and care staff were sometimes asked to cook meals for everyone in the home instead of offering social support. One member of staff said "Sometimes we have extra staff to allow for someone to be released to do the cooking but other times we don't and that means we are one person short." Staff also told us that the manager often assisted with the cooking and this helped but this wasn't always the case and generally staff felt this was an

added to pressure to every shift. We spoke with the manager and we could see a cook had been recruited to previously however they had failed to take up the position. At the time of our inspection another cook had been recruited and they were waiting for pre-employment checks to be completed before they could start working in the home.

Accidents and incidents were not always monitored and the correct procedures were not always followed when recording incidents. Staff we spoke with made us aware of a recent incident but when speaking with the manager it was apparent that the manager was not aware of the incident. Staff had recorded the incident on an accident and incident form but had failed to enter the details onto the appropriate monitoring system which would have ensured the manager would have been alerted to it. However, staff had also written a message in a communication book to alert the manager to the incident but the appropriate action had not been taken. There was a risk that accidents and incidents were not monitored and recorded effectively and appropriate action to reduce the risks to people had not been taken. We were advised by the regional manager that all staff would be reminded of the incident reporting procedures.

People told us they felt safe with the staff that supported them. One person told us, "Staff know what they are doing, they are quick to notice if I am not well." A visitor told us, "The staff do look after everyone very well." Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us "I would report anything if I thought our residents were not being treated right." Staff had received training on protecting people from abuse and records we saw confirmed this.

Regular maintenance and safety checks were made on all areas of the home including safety equipment, water supplies and the fire alarm. People had personal emergency evacuation plans in place in case of an emergency; these were in place to enable staff to see clearly in an emergency situation the level of support people required.

People's medicines were safely managed. Care plans and risk assessments were in place when people needed staff support to manage their medicines. One person told us "The staff always make sure I have my tablets; they never forget." Staff told us that they were trained in the administration of medicines and the registered manager had tested their competency. There was information available which detailed what medicines people were prescribed, however some of these required updating.

There were appropriate recruitment practices in place to ensure people were safeguarded against the risk of being cared for by unsuitable staff. Staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they commenced their employment.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback about whether people were cared for by staff who felt supported by the management team. One staff member told us "I don't always feel listened to; I have been raising my concerns that residents are not getting their key-working time but it still continues to happen." Another staff member said "I am listened to but things never get sorted out, there always seems to be excuses why action hasn't been taken." Another member of staff told us, "I think the manager is just too busy, run of their feet and can't do everything." Staff told us and records confirmed that staff received formal supervisions and annual appraisals; however the general feedback was that staff thought they did not feel listened to. Staff told us that this had led to a low moral within the staff team.

People's healthcare needs were not always monitored and action had not always been taken in a timely manner. For example: It had been identified in a care plan audit that a person who required their weight monitoring and not been weighed for several months. It was also identified on the audit that this person required a medical appointment to be made in relation to diabetes; however records showed this hadn't been completed. We raised our concerns with the manager who offered assurances that the person would be weighed and an appointment would be made for a diabetes check. Care records showed that people had access to community nurses and GP's and were referred to specialist services for example; mobility assessments. One person told us "I can see the Doctor whenever I want to; it has never been a problem."

People received care and support from staff that had the knowledge and experience to carry out their roles. People told us that they were confident in the staff and felt they were all well trained and understood their responsibilities. One person told us, "The staff use the hoist to get me out of my wheelchair and I trust them completely."

The staff spoke positively of the training they had received. All new staff undertook a thorough induction programme which included having their competencies tested in relation to manual handling, health and safety, safeguarding and medicine administration. They had worked alongside an experienced care staff member, before they had worked alone. All new staff were expected to undertake the Care Certificate; the Certificate aims to give employers and people who receive care the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One member of staff told us, "The training here is very good; I learnt a lot on the challenging behaviour course especially how to diffuse a situation."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

The management and staff were knowledgeable and experienced in the requirements of the MCA and DoLS. Detailed assessments had been conducted to determine people's ability to make specific decisions and where appropriate DoLS authorisations had been obtained from the local authority. All levels of staff had training in the MCA and DoLS and had a good understanding of service users' rights regarding choice; they carefully considered whether people had the capacity to make specific decisions in their daily lives and where they were unable, decisions were made in their best interests. One person told us "I always get choices, sometimes too many!" We observed care staff checking for people's consent before undertaking tasks with them.

Staff assessed people's risk of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). People were referred to their GP and dietician for further guidance when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely, for example where people had difficulty in swallowing, they followed the health professionals advice to provide food that had been pureed or thickened their drinks to help prevent choking. All staff ensured people were provided with meals that met their nutritional and cultural needs and there was an easy read guidance form which clearly set people's dietary needs including any adapted crockery and cutlery a person required which helped to guide staff.

Requires Improvement

Is the service caring?

Our findings

There was mixed feedback about whether people were supported with kindness and respect. The staff told us that they treated people with kindness and respect; however, people's views were not always the same. One person told us, "I don't think it is kind to not be able to take me to a funeral that I asked to go to and they [All staff and the manager] knew well in advance. It worries me that they wouldn't be able to support me to a relative's funeral if they died. I was so upset about it." Another person gave us 'thumbs up' to indicate to us that they thought the staff were kind and caring.

We observed that staff treated people with kindness and respect when they were talking to them and checking people were comfortable, however we also saw on one occasion where a person wasn't treated as well. This person had been out of the home all day and had not had a hot meal. Upon returning they were asked to choose what sandwiches they wanted for tea-time. This person said they hadn't had a hot meal; the care staff continued to ask what choice of sandwiches they wanted, this conversation continued until the person said 'Is there something warm I could eat' at which point after a period of silence they were told 'I suppose I could do you some beans on toast'. After the staff left the room this person told us "It is lucky I can speak for myself, others can't. It makes me feel like I am 'putting on the staff'." We informed the manager of our concerns and we were informed they would address this.

People were not supported to develop or maintain their independence skills. Each person had their own self-contained flat within the building which was not used effectively. We were informed that people had agreed to staff cooking and preparing their meals; however this had limited the opportunities for people to maintain and enhance their independence skills. People and care staff told us that people used to be supported with making their own breakfast and light evening meals in their own flats; however this no longer happened. Staff felt that they and people using the service had become institutionalised and independence was not promoted or encouraged in care planning and goal setting. Two people we spoke with told us they 'couldn't be bothered' to make their meals and it was 'easier to let staff do it'. One member of staff told us, "It is a waste of resources really, most people just sleep in their flats and everything else happens in the communal areas." Staff confirmed that all of the meals were cooked and prepared by a staff member for everyone living at the home. One person told us they were disappointed that they no longer went grocery shopping. They told us "I used to go shopping for my food that I would cook with staff at tea-time but it doesn't happen anymore." We spoke with the management team about promoting independence for people and they agreed that the current situation was not the position they wanted to be in and they would be looking at how to re-shape the service to offer more enablement.

People told us they had good relationships with staff. One person said "Staff are lovely; they do their best but I think sometimes they are just really busy." Two people we spoke with gave us 'thumbs up' when we asked about relationships with staff. One visitor told us "They [Staff] do know people really well and know the little signs that maybe someone isn't too happy." We observed that most interactions between staff and people using the service were positive and encouraging. One member of staff told us "I've worked here for a number of years and I really enjoy supporting people. We get to know people so well that we build a relationship with them which I think helps when you are doing tasks that are really personal like helping

them in the shower."

We observed that two people who spent most of their time in their flats were checked regularly by staff and interaction was positive and friendly. At every opportunity staff asked these two people if they were comfortable, if they wanted anything including food and drinks and companionship. When people used their call bell we saw that staff responded promptly. One person told us "I do use my bell a lot and sometimes it is just to ask something but they always come quickly."

People's preferences for care were incorporated into their daily care, for example one person preferred to be called by a different name and we saw that staff respected their wish. People were helped to maintain family relationships. One person said "My family come and visit often and if they call me I can take the call in my flat so I can have a private conversation with them."

People's privacy and dignity were respected. One person told us, "Staff respect when I want time alone." Another person told us, "All the staff are very good when it comes to my personal care, they close the curtains and always check with me that I am happy and comfortable; I can't complain about that side of things."

Requires Improvement

Is the service responsive?

Our findings

People and staff told us that social opportunities were limited, people didn't always receive their key-working sessions and one person didn't always receive their fully funded one to one hours. One member of staff told us, "Sometimes we are rushed, I can't say we are short staffed but rushed, and this can mean that not everyone gets their planned key-working time." [Key-working time in this service included shopping for personal items and support with cleaning and tidying people's flats.] One person told us, "I am supposed to get ten one to one hours per week but I only get four or five on a Monday; it's been like this for a while." Another member of staff told us, "We used to have more staff working on the disco night so people could go, this rarely happens now so only a couple of people get to go." This member of staff went on to tell us about a couple of times when key-working sessions had been recorded as taken place but hadn't happened. We spoke with the manager about this concern that was raised and we were informed that care staff sometimes forgot to record key-working time. The manager often recorded this time for the staff going by the planned times on the rota; and didn't check the activities had taken place.

People and staff told us about issues with transport which limited their social outings. Some people using the service had large specialised wheelchairs that were unable to fit in a standard wheelchair accessible taxi. There was only a limited number of staff who were trained to be able to drive the mini-bus which limited the days people could access the wider community. One member of staff told us "We have staff who have nearly finished their bus training but haven't been signed off by the manager; it has been that way for a long time." One person told us, "I am fed up with just shopping in Wellingborough, it would be nice to go somewhere out of town for lunch sometimes."

People had information about how to make a complaint or make comments about their care; but staff told us these concerns were not often recorded. Care staff gave us examples of the concerns people had raised relating to access to activities, access to the community and concerns about another person's behaviour in the home. Staff told us they had not written these concerns down or hadn't thought of these concerns as complaints. The impact of staff not following the providers complaints procedure was that people's concerns could not be fully investigated by the management team and people continued to receive a service they were dissatisfied with.

People received a full assessment of their care needs prior to living at Southwood House. People and their relatives or advocates were encouraged and supported to visit the home during the decision making process. We saw that the manager ensured they gathered as much information and knowledge about people during the pre-admission procedure from people themselves if they were able to communicate, and from relatives, advocates and professionals already involved in supporting each person. This ensured as smooth a transition as possible once the person decided they would like to move into the home.

People's care plans contained information that was relevant to them including their life histories, interests and activities. However, some care plans and risk assessments lacked the detail needed to provide person centred care to people and also omitted information relating to historic risks or concerns. Care plans contained people's goals and aspirations but there was limited evidence of how people progressed towards

their goals or what support they required. For example; one person's care plan stated they wanted to learn to read and write, there was no planned support in place to support this person and no updates in the care plan to record if any progress had been made. There was a concern that people's care plans were viewed as fixed documents which although they were reviewed monthly, they evidenced that the information contained within them had not been reviewed with the person to ascertain if information was still relevant and reflected people's aspirations.

People's preferences were recorded in their care plans and we saw that staff were aware of these and offered support to people in-line with their preferences. For example; one person requested only female care staff to support them with their personal care and staff told us and records showed this happened in practice. Another person preferred to communicate using their own picture book and we saw this was an accessible document and used by the person and the staff to communicate. One person told us "The do know us well; they know our routines and what we like and don't like."

Requires Improvement

Is the service well-led?

Our findings

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.'

The registered manager and manager lacked oversight of what the day to day culture was like in the home. Most staff told us that morale was low; they didn't feel listened to by the management team and felt the home lacked energy, positivity and direction. One member of staff told us "It is difficult to say exactly what is wrong; it is a build up of small things that just never keep getting resolved." Another member of staff said "I have worked here for a long time and it has only been the last 12 months or so that everything has gone 'flat'; that is the only way I can describe it." Another staff said "It feels like we are just drifting; the residents are cared for well but everything else just seems to be an uphill battle."

There were audits in place to monitor the effectiveness of the service; however these audits were did not capture the quality of the service and the documents that supported it. For example, audits had been completed on care plans but where actions had been identified these had not taken place and there was no follow up. Medication profiles had been reviewed monthly however they did not contain the accurate information on the prescribed medicines that people received. Risk assessments were not completed correctly. For example one risk assessment form stated 'if a person is not at risk of falls you do not need to complete this assessment'. This person was not at risk of falls and the assessment had been completed and reviewed monthly for two years. Other risk assessments had other people's names on them which gave a concern that the management of risks were generic and the same information on how to mitigate the risk had been copied onto each person's risk assessment not taking into account people's diverse needs.

Records were completed to evidence that people had received key-working time; however it had not been checked to see if the person had actually had this time and we found on more than one occasion the records were inaccurate. One person only received half of their one to one funded hours and this had not been recognised by the registered manager or manager. People were not able to access the community and attend events as often as they liked. Access was limited because of staffing numbers, appropriate trained staff to drive the accessible vehicle and lack of planning.

Staff were not following the provider's accident and incident reporting procedures. When an incident had taken place it was not recorded on the appropriate system and although all staff were aware of the incident they did not ensure the correct procedures were followed.

Independence was not encouraged or promoted. Staff told us that they felt people had become institutionalised and they had become used to staff completing most tasks for them like preparing meals because people no longer wanted to do this for themselves. There was no information in people's care plans that provided information on supporting people to remain independent and developing new skills.

Risks to people had not been assessed in relation to accessing the main living areas of the home by supported living tenants and their visitors. Visitors to the supported living tenants were able to use the main areas of the home and the risk that this posed had not been considered.

The provider's statement of purpose which is document that sets out what the service will deliver was out of date in the main reception area of the home.

There was a lack of oversight by the provider and registered manager to effectively assess, monitor and improve the quality and safety of the services provided.

At the time of our inspection the previous inspection rating was not displayed as required. Following our inspection the previous ratings for the service are now displayed.

This was a breach of Regulation 17 (1) Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider kept the staff team up to date with current information relating to the organisation by publishing an 'industry newsletter' and also a company magazine which included information for staff and 'good news stories' from across all of the services.

Staff were positive about the training they received and said the training was a good standard and provided sufficient knowledge to enable them to carry out their roles effectively. There were opportunities for staff to progress within the organisation and courses and training were available to increase their knowledge and skills.

The provider had ensured that appropriate professional support was available for staff following a recent traumatic event. Staff told us that the support was welcomed and that a confidential person to talk to had helped them feel more able have clarity about the event.

People were able to rely upon timely repairs being made to the premises and scheduled servicing of equipment. Records were kept of maintenance issues and the action taken to rectify faults or effect repairs.

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 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight by the provider and registered manager to effectively assess, monitor and improve the quality and safety of the services provided.