Care Quality Commission

Southwinds Limited

Southwinds

Inspection report

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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

Overall summary

We inspected this service on 17 March 2015. The inspection was unannounced. The service provides accommodation and personal care for up to 25 people. There were 13 people living in the home on the day of our inspection.

There was a registered manager 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.

At the last inspection in September 2014 compliance actions were issued as the provider was breaching legal requirements in the way medicines were managed. At this inspection we issued the provider with a warning notice as we found improvements were still required.

Summary of findings

People told us they felt safe but we found they were not fully protected from risk because some of their risks had not been recognised or suitably assessed.

There had been no actions taken to update or identify some risks which affected the health and safety of people living in the home.

Staff received training to update their knowledge to care for people effectively. Staff were not provided with structured support systems to reflect on the care they provided to ensure their performance met people's needs. Staff told us the understood the requirements of the Mental Capacity Act 2005 but did not put this into practice.

People were not involved in planning their care so that it met their individual needs, abilities and preferences. Staff chatted to people whilst they were delivering care but people were not supported to make choices for themselves about how they wanted to spend their time. People were not encouraged to maintain their independence or maintain independent living skills. People had limited involvement with the community they lived in.

There were no arrangements in place to monitor the quality of the service and use this information to improve care for people. People living in the home were provided with meetings but were not encouraged to express their views anonymously, if they preferred, in a satisfaction survey.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches 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.

Summary of findings

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 consistently safe. Concerns we had raised at our last inspection about the management of medicines had not been addressed. Risks to people had not been fully assessed and some people were not being supported in the way they required. Staffing was not planned to reflect people's changing needs.

Requires Improvement

Is the service effective?
The service was not consistently effective. Staff did not receive individual support to review their performance and support their professional development. People had access to healthcare professionals to support their health and well-being.

Requires Improvement

Is the service caring?
The service was not consistently caring. Staff spoke with kindness to people but did not treat people as individuals. People's privacy and dignity was not respected by some members of staff.

Requires Improvement

Is the service responsive?
The service was not consistently responsive. People were not supported to be involved with the community on a regular basis. People were not involved in planning their care to meet their preferences.

Requires Improvement

Is the service well-led?
The service was not consistently well-led. The registered manager was not monitoring the quality of the service to identify if changes were required. Some records were inaccurate and contained information which had not been updated for some time. There were no procedures in place to support staff who wanted to raise concerns about the organisation.

Requires Improvement

Southwinds

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 inspected this service on 17 March 2015. The inspection was unannounced. This inspection was undertaken by two inspectors.

The provider completed a provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who used the service, three relatives, two care staff, the registered manager and the deputy manager. We looked at the care plans for five people, four staff recruitment files and documents associated with the management of the home.

We also reviewed the information we held about the service. We looked at information received from relatives, from external organisations such as the local authority and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which affect the service, which the provider is required to send us by law.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 10 September 2014 we found the provider was not meeting our regulatory requirements for the management of medicines and this was having a moderate impact on people who used the service. The provider sent us an action plan on 30 November 2014 with information about how they would improve the way people's medicines were managed.

At this inspection we found the management of medicines was still not adequate to ensure people received their medicines appropriately as prescribed. We issued the provider with a warning notice and told them they must improve the way they managed medicines by 18 May 2015.

One person was administering their own medicines, they told us, "I've always done it". There had been a risk assessment completed for their self-medication but there were no processes in place to ensure their medicines were stored securely. The medicine could present a risk if taken by other people who used the service. We also observed that ointments and creams prescribed for people were stored in bathrooms where they would be accessible by people who did not need them.

Another person was receiving a homely remedy; this is a medicine which is available to buy over the counter. The use of homely medicines in care homes should be agreed between the home and the person's GP. The registered manager told us the GP had agreed their use but this was not recorded as required, on the person's medicine administration record (MAR).

Another person had been prescribed medicine to be used 'as necessary'. The medicine was for use in an emergency. There were no guidelines provided to staff to inform them of the circumstances when the medicine should be used or the frequency it could be administered safely. Staff we spoke with did not have a clear understanding of the use of this medicine which could delay the treatment of the person in an emergency situation.

We looked at the MAR for five people. Two people's records we looked at showed they were not receiving the prescribed dosage of their medicine. One person was not receiving sufficient medicine and the other person was receiving more than had been prescribed for them. Another person had no medicine for pain relief in stock although it was recorded on their MAR that they had been receiving the medicine. The registered manager told us they had bought the medicine over the counter for them but was unable to provide us with the box to show us this medicine was available. The person was unable to have their pain relief medicine on the day of our inspection as the provider did not have stock available for them.

This is a breach of Regulation 13 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's management of risk included risk assessments for people's mobility but the plans did not provide clear guidance for staff to ensure people were supported in safe way. The assessments contained some information about people's requirements for moving and handling, for example if they required support from one or two members of staff but we found the information was not always accurate. We read in one person's care plan that they needed personal care and support to change their position to protect their skin from the risk of pressure, particularly when they were in bed. There was no information provided about how frequently the person should be moved to protect their fragile skin. During the day we saw this person was supported by two members of staff as they were not able to move themselves. The registered manager told us this person did not need two care staff at night as they were able to move themselves in bed when prompted. This information was not recorded on the assessment. We saw another person was not supported to move in the way their risk assessment described. The person was moved in an unsafe way which could cause injury to them. One person who used the service helped the registered manager prepare food for the teatime meal. The registered manager told us that the person's involvement was restricted so that they were not at risk. There was no risk assessment in place to identify what tasks the person could do safely or those they needed supervision with to ensure their safety. A member of staff we spoke with was unable to tell us what kitchen tasks the person was able to complete without support which demonstrated an inconsistency.

One person shared a bedroom with a person who smoked however no risk assessment had been completed which recognised the risk to the non-smoker's comfort. We saw

Requires Improvement

Is the service safe?

that annual review dates were recorded on other risk assessments, but there had been no amendments made for several years to reflect people's changing preferences or levels of risk.

The personal emergency evacuation plans were not accurate as they did not reflect changes in people's location in the home or their mobility. These plans are used to ensure people can be located quickly and supported appropriately should an emergency such as a fire occur.

Some accidents and incidents were reported and recorded however the information was not used to identify how further incidents could, if possible, be avoided.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information of concern regarding the staffing arrangements at the home, particularly the number of staff available to support people overnight. We looked at the staffing rotas and saw that care was provided by the registered manager, the deputy manager and one carer during the day. There was one member of staff working at night. Staff we spoke with told us they called for the registered manager, who lived on the premises, if they needed additional support at night, particularly if there was an emergency. We saw there were enough staff to support people during the day. There were no systems in place to show the registered manager recognised and considered people's changing needs and dependencies when planning staffing levels.

Staff had received training in safeguarding people. Staff were able to tell us how they kept people safe and protected them from the risk of abuse. One member of staff said, "I watch out for changes in people's behaviour. A change could mean they had been treated badly by someone". Staff explained the actions they would take in response to their concerns. One member of staff said, "I would record it and tell the manager". We asked people if they felt safe living at Southwinds. One person said, "I'm alright here, the doors are all locked". Another person told us, "Nobody can touch me. I'm safe here". A relative we contacted told us, "Yes, [Name] is definitely safe living there".

We looked at recruitment records for six members of staff and saw there were processes in place to ensure staff were suitable to care for people who used the service. We saw staff were asked to provide information about their previous work experience and supply appropriate contacts to approach for references before being employed. The staff working at the home had undergone checks by the disclosure and barring service (DBS). The DBS provides information about past criminal offences for potential employees.

Is the service effective?

Our findings

There were no supervision arrangements in place to support staff or offer them opportunities to discuss their performance and development. Staff told us they were aware the registered manager observed the way they provided care, on an ad-hoc basis. We saw written notes regarding staff observation but there was no record that actions were taken to improve people's care, based on the observation.

Staff told us they had access to training. We saw that the programme of training had recently been increased in response to concerns raised during a local authority quality monitoring inspection. The training records provided information about the training staff had completed. Staff we spoke with told us they received training either on the internet or 'face to face' by an external company. One member of staff told us, "We've done a lot of training recently". People told us they were happy living at the home. One person said, "I like living here. They [the staff] look after me". A relative told us, "The staff know what they're doing".

We did not hear staff asking for consent from people before delivering care. People were not involved in decisions about their meals. They told us they hadn't been asked for their food choice that day and didn't know what they were having for lunch. At lunchtime food was put in front of people without comment or explanation. One person said, "We usually know what we're getting. We always have cold meat on Monday". People were given drinks at set times during the day. We saw people went to the table to have their drink rather than remain in their chairs. People we spoke with told us the staff told them they had to sit at the table. One person said, "We have to so we don't spill it on the settee". This demonstrated a lack of involvement and choice for the people who used the service.

Staff we spoke with told us that some people who used the service were unable to make decisions about their health, safety and welfare for themselves. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure, when appropriate, decisions are made in people's best interest to protect their health and wellbeing when they are unable to do so for themselves. Staff told us they understood the requirements of the MCA but did not demonstrate that they put this into practice. They told us, that if people did not have capacity, they would make their decisions for them and if necessary involve health care professionals. Staff had not recorded capacity assessments or best interest decisions, as is required, to demonstrate people's statutory rights had been considered before changes had been made to their care.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been no DoLS applications for people living in the home. The registered manager told us that people could go out if they wanted to.

People were supported when they had specific dietary requirements to maintain their physical health. For instance one person needed food which had been mashed to ensure they could swallow it. We saw that staff observed them and reminded them to 'slow down' when they were eating too quickly. We saw that people's weight was monitored on a regular basis to check it was suitable.

The care plans we looked at contained information about other services people were referred to for health, social and mental health support. One person told us, "I was in hospital. The doctor comes to see me here". A relative told us, "[Name] is having some medical treatment at the moment. They usually walk to the surgery with staff to see the GP and have their blood tests. The staff always let me know if there's anything wrong". Another relative told us, "[Name] goes to the optician and the dentist regularly. The staff make sure of that". A health care professional told us, "If I raise a concern that a person needs to be referred the staff listen to me and take the appropriate action. A member of staff does support people when they attend for hospital appointments". This demonstrated people were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

People did not receive personalised care which promoted their independence and individuality. We saw people were told, prior to their lunch, that they needed to wash their hands They stood together and queued for the bathroom and then queued again to return back into the lounge. The care plans did not contain any information to demonstrate that people were encouraged and supported to gain the living skills they required to retain their independence.

People's dignity was not supported. We heard staff in the communal areas of the home openly discussing people and their personal needs. One member of staff said, "Has [Name] been to the toilet yet? They probably haven't I'll take them now". Some people needed to use personal continence aids to keep them comfortable. Staff told us there was an allocation of three pads per person per day and the remainder were locked away. We saw one person was not supported to move position nor have their personal needs met for several hours. The person's care plan included information that being supported to remain clean and dry was important to them.

Some people were unable to tell us about their experience of care and we observed the care being provided in the communal areas of the home We observed that some people did not have control over how they spent their time.

We saw one person did not want to be involved in a music and exercise session. Staff moved the person into the group on four occasions despite them making it clear to staff that they did not want to take part. The person eventually swore at staff and was admonished for their use of bad language. People told us they could get up when they wanted but went to bed 'when they were told to'. One person said, "I go to bed at nine, we can't stay up late, we're not allowed". We saw one person had been moved to another bedroom. The person told us, "My new room's alright but I didn't choose it".

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201 which corresponds to Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were well cared for and were happy living at Southwinds. One person said, "I like living here. They [the staff] look after me". A relative told us, "[Name] is happy there and we've always been very happy with the way they are looked after". Another relative said, "They're like one big happy family".

People were able to maintain relationships with their family and friends. Relatives told us they could visit whenever they wanted. One relative said," I come and visit regularly and take [Name] out. The staff are always welcoming". Another relative told us, "[Name] is happy, very content living there".

Requires Improvement

Is the service responsive?

Our findings

People had lived in the home for many years, the staff turnover was low and the staff we spoke with knew people's life history and family relationships. We saw the care plans contained a one page profile with some information about what was important to people, for example their dietary preferences.

Only one of the five care plans we looked at demonstrated that people or their representatives had been consulted with. Information in people's care plans was not presented in a format which met their needs, for example by using pictorial information and signage. People we spoke with were not aware of their care plans or their right to manage their own care with support from staff

One person said, "The staff do all that". Most people were unable to tell us if they were involved in agreeing and planning their care. One relative we spoke with said, "They usually contact me to let me know what's been arranged".

When we arrived for our inspection two people were out. One person was involved in voluntary work. Another person was attending a day care service but this was due to finish. The person told us they would miss going out. The registered manager told us there were no plans in place to find an alternative activity for this person so that they could remain involved with the community. The people remaining in the home told us they didn't leave the home very often. Two people told us they liked to work in the garden. One person said, "I have my own brush to sweep up the leaves and I rake up the moss from the grass". Another person enjoyed drawing and doing crafts and showed us pictures they had done. The person told us their pictures were sent somewhere by staff but they did not know where. There were no examples of their handiwork on show in the home. One person told us they enjoyed doing 'household jobs' and we saw them cleaning and hanging out washing. The person told us, "They [the staff] give me pocket money so I can buy my soap and toiletries. My [relative] takes me out. I can't go until I've finished my chores". The staff told us, "Only two people go out regularly unless they go with their relatives".

We saw people making Easter cards with assistance from staff but did not hear people being given a choice about this. In the afternoon there was music and game playing, again supported by a member of staff. We saw that people enjoyed the activities and except for one person were keen to participate. When there wasn't an organised activity taking place people did some colouring.

People were provided with resident's meetings. According to the home's statement of purpose these were held monthly. We looked at the minutes of the last meeting which had been held four months previously to discuss people's individual arrangements for the Christmas period but there were no discussions recorded to indicate that people had been asked for their views on the service or if they were happy with their care.

There was information about making a complaint displayed in the hall area of the home. The registered manager told us no complaints had been received since our last inspection. People we spoke with told us they would speak to the registered manager if they were worried or concerned about anything. One person said, "I would tell Miss [the registered manager] if I was worried". A relative told us, "I wouldn't hesitate to go to the manager if I was unhappy about anything".

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not gathering information to drive improvement in the service they provided. There was no audit process in place to monitor the quality of care in the home, such as care plan entries to check that these were accurate, appropriately written and contained sufficient information to check that people were receiving the correct care. There were no effective arrangements in place to look at incidents which occurred in the home which might affect people's health and safety and the identification of any trends which could be used to minimise risks to people. For example, we saw a pot plant fall from the top of a shelf unit onto a member of staff; narrowly missing the person they were supporting to have a drink. The plant was returned to its original position without consideration of the risk this presented.

People were not involved in making decisions about their care or encouraged to share their ideas about how the home was run. The provider told us they had issued people and their families with satisfaction surveys in the past however the only copy they could show us was undated and they were unable to tell us when it had been completed. Relatives we spoke with were uncertain when they had last been asked to share their opinions of the care provided to their family.

There were no organisational arrangements in place to protect staff who wanted to raise concerns about the service either directly or anonymously, if they preferred to protect their identity. Staff told us they would speak to the manager if they were worried about anything but did not know if there was a whistle blowing policy in place. A whistle blower is a member of staff who raises concerns about the way a service is run. The registered manager was unable to provide a policy for us to look at.

The registered manager sent us a Provider Information Return (PIR) but we found the information provided was not corroborated at the inspection. For example, the PIR documented that care plans were regularly reviewed and maintained. We saw that care plan review dates had been recorded but there was no information provided to indicate that people's needs had been fully assessed and updated. The PIR also indicated that there were policies in place to guide staff however the registered manager was unable to provide a policy to support staff who wished to raise concerns anonymously, about the service. The registered manager had not included any information for the caring section of the PIR.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager worked in the home from 07.00 hours until 23.00 every day and told us, as she lived at the home, she was also available to be called overnight. The registered manager told us she did not take any holiday and had never been off sick but if additional cover was required she would contact the deputy manager who lived close by. People we spoke with told us they knew who she was and referred to her as 'Miss'.

Staff told us and we saw from the minutes that meetings were provided for them on an occasional basis. Staff told us they discussed staffing levels especially over holiday periods and the last meeting had been prior to the Christmas period.

The registered manager was fulfilling their regulatory responsibilities by submitting notifications about important events which happened in the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment which corresponds to Regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines which corresponds to Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. the registered person was not protecting service users against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered person was not protecting service users against the risk of inappropriate or unsafe care and treatment by identifying and managing risks or assessing and monitoring the quality of the service provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines which corresponds to Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
Warning notice