# Southwinds Limited

# Southwinds

## Inspection report

17 Chase Road
Burntwood
Staffordshire
WS7 0DS
Tel: 01543 672552

Date of inspection visit: 13 August 2015
Date of publication: 13/10/2015

## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Inadequate** |
| Is the service safe? | **Requires improvement** |
| Is the service caring? | **Requires improvement** |
| Is the service well-led? | **Inadequate** |

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 March 2015. Breaches of the legal requirements for the management of medicines, consent to care, arrangements for people's care and welfare and the management of the home were found. After the comprehensive inspection the provider wrote to us to say what they would do to meet the breach of the legal requirements in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 but did not include an action plan for the other breaches we identified.

We undertook this focused inspection on 13 August 2015 to check that they had followed their plan for improving the management of medicines and to confirm that they now met the legal requirements in all the areas in of concern we identified. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Southwinds on our website at www.cqc.org.uk

Southwinds provides accommodation and personal care for up to 25 people with a learning disability. There were 14 people living in the home on the day of our inspection.

You can read a summary of our findings from both inspections below.

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.

# Summary of findings

At the focused inspection on 13 August 2015 we found the registered manager had made improvements to the way people's medicines were managed. People's prescriptions had been reviewed to ensure their prescribed medicines met their needs. However, reviews had not been carried out for some people who received pain relief medicines on an 'as required basis' to ensure their pain was still being managed appropriately.

At our last inspection we found there were no arrangements in place to monitor the quality of the service so that the information could be used to improve care for people. At the focused inspection we saw the registered manager had taken no action to address our concerns or meet the legal requirements of the Health and Social Care Act. The provider had not put in place arrangements to monitor the quality of the service including the need to check the accuracy of the care plans. People's level of risk was not reviewed regularly or updated to reflect accidents and incidents that had occurred, which could affect their safety. People living in the home had not been provided with opportunities to express their views anonymously, if they preferred, in a satisfaction survey.

We found 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?**

We found that actions had been taken to improve the safety of medicines but further improvements were required. Some people's requirements for regular pain relief still needed to be reviewed. There were processes in place to store, administer and record medicines correctly.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

**Requires improvement**

**Is the service caring?**

We found that action had not been taken to improve caring. Some people were not supported to receive dignified care which met their needs and preferences. People were not included in decisions about their care and support.

**Requires improvement**

**Is the service well-led?**

We found that action had not been taken to improve caring. Some people were not supported to receive dignified care which met their needs and preferences. People were not included in decisions about their care and support.

**Inadequate**

# 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 was 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 an unannounced focused inspection of Southwinds on 13 August 2015. This inspection was completed to check that improvements to meet the legal requirements planned by the provider after our comprehensive inspection on 17 March 2015 had been made. The team inspected the service against three of the five questions we ask about the service: is the service safe, is the service caring and is the service well-led. This was because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors. Before the inspection we reviewed the information we held about the home and spoke with the local authority's quality monitoring team.

At the visit to the home we spoke with five people who lived there, the registered manager, the deputy manager and a member of the care staff. We also looked at the care plans for four people and records relating to the management of the home.

Requires improvement

# Is the service safe?

## Our findings

At our comprehensive inspection of Southwinds on 17 March 2015 we found that the management of medicines was not safe. People were not receiving their prescribed medicines correctly, medicines were not stored safely and there were no effective processes in place to ensure adequate stock control was maintained.

This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the way medicines were managed by 18 May 2015.

At our focused inspection on 13 August 2015 we found that the provider had followed the action plan they had written to meet the shortfalls in relation to the requirements of Regulation 12 described above. However, we found further improvements were still required.

One person had been administering their own medicines but at our last inspection we found these were not stored securely. At this inspection, we saw that the person's medicines had been moved to a secure storage facility. The person still administered their own medicine however this was completed in the company of staff to ensure the medicine was returned to safe storage in the office. The person told us, “After you came before I was told I had to stop looking after my medicines”. There was no risk assessment in place to show if other options had been considered. For example, the provision of a locked box in the person’s room or the introduction of frequent checks on the storage so that the person could maintain their independence

We saw that people's medicines had been reviewed by their doctor, as required, following our last inspection. Changes had been made to ensure that people received the correct medicines. However, we saw that some people were still prescribed medicines on an 'as and when required' basis but were receiving the medicine every day. The registered manager had not recognised that the person pain relief requirements had increased. This meant their prescription no longer met their needs and should be reviewed to ensure they received adequate pain relief medicine.

We checked the medicine administration records for four people and saw these had been completed correctly. We checked the medicine stock levels and found the amount in stock tallied with the records. This demonstrated that the provider had implemented a stock control system to ensure there were adequate amounts of medicine available to people. We saw that the arrangements for the storage of external preparations, for example, creams and ointments had been improved. This reduced the risk of other people living at the home using the medicines inappropriately.

Requires improvement

# Is the service caring?

## Our findings

At our comprehensive inspection of Southwinds on 17 March 2015 we found that some people's dignity was not supported by staff and their preferences for care were not recognised. These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not respond to our request to provide an action plan setting out how they would meet the legal requirements associated with this breach.

At our focused inspection on 13 August 2015 we saw people were still not involved in the way their care and support was planned. One person told us, “I like dancing but I don’t go anymore. I’d like to though”. Another person said, “I don’t go out. I used to like going into the garden but nobody takes me anymore”. This demonstrated that people’s care and support did not meet their preferences.

One person we had raised concerns about at our last inspection was still not receiving the care they required to meet their needs. This person needed help and support from two members of staff to move regularly when they were sitting or lying in bed. This was necessary to avoid them developing pressure damage to their skin. We read in the person's care plan that being supported to remain clean and dry was important to them. We saw the person was not supported to move position or have their personal needs met for several hours during our inspection. This person had recently been seen by a health care professional who had advised that they should wear support hosiery and their legs should be elevated to reduce the swelling in their legs. A member of staff told us the hosiery was no longer necessary but we observed that their legs and feet were swollen.

When the person was moved in the afternoon, this was done in a way that did not support their dignity or recognise the discomfort the person vocally expressed as they were moved. There was no information recorded in the person’s care plan to support the staff on how to move the person safely and comfortably. This demonstrated that staff did not promote the person’s health and well-being or provide care in the way they preferred.

Another person needed to be observed to ensure they did not eat their meal too quickly. We read, in the person’s care plan that they frequently displayed behaviour that challenged at mealtimes. We saw during lunch, the registered manager stood over the person and held their arm down to reduce the speed that they were eating their meal. We heard the person becoming increasingly distressed and vocal by this restriction. This demonstrated that people’s dignity and independence was not recognised and promoted by staff.

We read in another person’s care plan that their drinks should be thickened to reduce the risk of them choking. On two occasions we saw the person being offered drinks which did not meet the required consistency. We had to intervene on both occasions. A member of staff said, “It doesn’t look very syrupy”, but had been prepared to give the drink if we had not stopped them. This meant staff had not followed specialist advice designed to protect the person’s health.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

# Is the service well-led?

## Our findings

At our comprehensive inspection on 17 March 2015 we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. These related to the management of people's risks, the failure of the provider to monitor the quality of the service and the lack of opportunities for people to offer their views about the care they received. At the focused inspection on 13 August 2015 we found the provider had not taken actions to meet any of the shortfalls we had identified previously.

Staff told us they would speak to the registered manager if they had any concerns, for example about safeguarding but did not feel empowered to take responsibility for reporting themselves. Staff told us they were not aware of a whistleblowing policy at the home. The registered manager could not provide us with a policy or confirm if they had one in place. Staff were not provided with supervision. One member of staff said, “No, we don’t have those”. This meant there were no opportunities for staff to discuss their personal development.

The provider had not put in place effective arrangements to monitor incidents which might affect people's health and safety. We saw that two people had sustained injuries following falls. One person had fallen on three occasions since the last review of their risk assessment. No amendment had been made to their risk assessment following the falls to reflect the need for a change in the level of support they required to move safely. The other person had been hospitalised following a fall but there had been no review of their identified risks to ensure they were supported appropriately. Another person's care plan recorded that they had seizures. We saw that the date of the last seizure recorded in the person's care plan was incorrect. We saw that the person had been transferred to hospital on three occasions for treatment following seizures since the date recorded in their care plan. There had been no review of the care plan or guidance for staff on the best way to support the person. A member of staff was unable to tell us how they would support the person and said, “I’d get [Name], the registered manager, they deal with things like that”. This demonstrated people's risk assessments had not been reviewed or guidance was provided to staff to ensure risks were identified to keep people safe.

At our previous inspection we saw that the personal emergency evacuation plans (PEEP) were incorrect and had not been updated to reflect people's location in the home. At this inspection we saw the provider had failed to amend the emergency plans. The plans referred to people having rooms in the annexe which was no longer used for accommodation. The PEEP for one person stated they needed prompting to move. However we saw this was inaccurate as the person required assistance from two members of staff to move. The failure to record accurate information could lead to delays in evacuating people safely in an emergency.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that must be in place to support people who are unable to make important decisions for themselves. At our last inspection we found that mental capacity and best interest decisions had not been completed, where required, to protect people's rights and this had still not been addressed when we undertook the focused inspection on 13 August 2015. This demonstrated that the provider did not understand their responsibility to meet the requirements of the Mental Capacity Act 2005.

The provider had still not carried out any audits to monitor the service people received to drive improvements where necessary. Effective systems to assess and monitor the safety of the service were not in place which put people who used the service at risk. For example, there were no audits to check that people’s care plans accurately reflected the care they required and received.

People and their relatives had still not been invited to give their views on the service using a satisfaction survey. This meant that people were not offered a way to share their views of the service they received, anonymously if they preferred. The manager had not acted on any of the concerns we highlighted at our last inspection. They did not provide an action plan, a statutory requirement, within the timescale we gave them or at any time to date.

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

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 (1), (2) (a),(b),(c),(f) 3 (a)(b)**<br>**Systems and processed must be established and operated effectively.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**Regulation 9 1 (b)(c) 3(I)(b)**<br>**The care and treatment of service users must meet their needs.** |

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>The registered person was not assessing, monitoring and improving the service. |

**The enforcement action we took:**
Warning Notice