Southwinds Limited

Southwinds

Inspection report

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Date of inspection visit:
01 December 2016

Date of publication:
16 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 1 December 2016. This comprehensive inspection was brought forward as a result of information received from the police and local authority about the way people were receiving care and support. The inspection did not look at the specific incident being investigated by the police but did look at whether people were being supported safely. The service was registered to provide accommodation for up to 25 people. At the time of our inspection, 13 people with learning disabilities were using the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Our last comprehensive inspection took place on 21 March 2016 and we found that actions were required to improve the care that people received. We told the provider to make improvements to ensure that they were acting lawfully when providing care and support to people who were not able to consent to this themselves. The provider should have sent us a report explaining the actions they would take to improve. However, they did not do this. At this inspection, we found insufficient improvements had been made. The provider had considered how they made decisions for people that were in their best interests, but they had not followed the guidance available.

People were not safe. The provider had not ensured that fire safety procedures were followed. We were not confident that there were enough staff to meet people's needs and keep them safe at all times. Risks to people were not managed effectively and some people were at risk of not having their medicines as prescribed. People were living in an environment that was not free from unpleasant odours and staff did not have easy access to protective equipment such as gloves when needed. Even though staff were aware of how to protect people from harm, we did not have assurance that the provider acted upon concerns that were raised.

Referrals to healthcare professionals were not always made in a timely manner and the provider did not consistently respond to people's changing healthcare needs. The provider did not support people to make choices about their meals, and drinks were not readily available to people when they wanted them.

People were not treated with dignity and respect, and they were not actively involved in making decisions about their day to day care. People had little choice or control in their lives and their care was not individual to them. They had limited involvement with the planning and review of their support, and people's opportunities to participate in activities were limited. Care records included some information that was personal to people, but important information was omitted. Records were not always available for staff to refer to when needed.

The provider did not manage the service to ensure that people received high quality care. The audits that were in place were ineffective and the overall culture was not empowering to the people who lived there. Some staff did not feel supported by the management team, and they were not encouraged to contribute to the development of the service. A positive open culture was not seen to be promoted and we were not assured that the provider understood their responsibilities as a registered person. The provider was not up to date with current practices, and some support given was not in line with their registration. We had not been informed of significant events when required.

Staff did receive an induction and training, and had some opportunities to discuss their work and roles. Some people's independence was promoted and their privacy was respected. Staff knew people well and we were told that the staff were kind. People were able to maintain family relationships that were important to them. There were some opportunities for people to share their views and they knew how to raise concerns.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Fire safety procedures were not followed and people lived in an environment that smelt unpleasant. We could not be assured that there were sufficient staff to meet people's needs and keep them safe at all times. Risks to people were not effectively assessed, managed or reviewed. Staff were aware of how to safeguard people, but we were not confident that the provider acted upon any concerns raised. Staff did not have easy access to protective equipment they needed. Medicines were stored safely but some people were at risk of not having these as prescribed.

Is the service effective?

Inadequate

The service was not effective.

The provider had considered how they made decisions for people that were in their best interests, but they had not followed the guidance available. People's healthcare needs were not responded to in a consistent or timely manner. They did not have ready access to drinks and they had little choice over their meals. Staff did receive an induction and training, and had some opportunities to discuss their work and roles.

Is the service caring?

Inadequate

The service was not always caring.

People's dignity was not promoted and they were not actively involved in making decisions about their care. People did not have choice or control in their lives. Some people's independence was encouraged and their privacy was respected. People were able to stay in contact with family members who were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care that was individual to them. They

had limited involvement with the planning and reviewing of their support. Some people were able to take part in activities they enjoyed, but these opportunities were limited. Some people were not enabled to take part in meaningful activities within the home. Care records included some information that was personal to people, but important information was omitted. People who used the service had some opportunities to share their views and they knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

We do not have confidence in the provider. The audits that were in place were ineffective and were not used to identify and bring about improvements. The overall culture of the service did not empower the people who lived there, and was not open and positive for the staff. Staff were not consistently supported by the management team and people were not actively involved in developing the service or their skills. The provider was not up to date with current practices, and some support given was not in line with their registration. We had not been informed of significant events when required.

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.

This inspection visit took place on 1 December 2016 and was unannounced. The inspection team consisted of two inspectors. At the time of our inspection, 13 people were using the service.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also received feedback from the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us a provider information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We spoke with five people who used the service, four members of care staff, the deputy manager and the registered manager. We received feedback from four community professionals who visited people who used the service. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We looked at the care plans of two people to see if they were accurate and up to date. We reviewed two staff files to see how staff were recruited and checked the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We also looked at records that related to the management of the service. This included the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Inadequate

Is the service safe?

Our findings

Our previous inspection found whilst the provider was not in breach of any regulations, there were aspects of the recruitment process that could be improved to ensure that staff were suitable to work with people. We reported on this in our last report. At this inspection, we found that the provider had taken note of our comments and had made improvements in relation to the references obtained for staff. We looked at two recruitment files. We saw and staff confirmed that references were obtained. One member of staff told us, "All the recruitment checks were in place, like my references and police check." However, the provider was not able to show us the police checks had taken place as the information was on the computer and they were not able to access this. We asked for this information to be sent to us, and we had not received it at the time of issuing the draft report on 20 December 2016. Therefore, we could not be sure that the provider had checked staff's suitability to work within the home.

At this inspection, we found other concerns relating to the safety of the people who used the service. We saw that towels had been draped over two fire doors. The registered manager told us, "The staff do that so the doors don't bang and disturb people." This meant that the fire doors would not shut properly and would not be effective. We saw that these towels had been left in place throughout the morning until we requested for them to be removed. We also saw that a compartment fire door had clothes hanging from the door closure that would have affected the mechanism working correctly. One staff member told us, "We are drying the clothes." We asked staff on three separate occasions for the clothing to be removed before this happened, as the doors would not work properly and people would be at risk if a fire broke out. Staff told us they had completed fire safety training which meant they should have understood the importance of fire doors being used correctly. This demonstrated that fire safety procedures were not followed to ensure people's safety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a malodourous smell of cat excrement in the home. We found this to be particularly offensive in the hallway, visitor's room and the front lounge. We saw there was a dirty cat litter tray in the visitor's room. One staff member told us, "I've seen the cats spraying in the home, and I've often had to pick up cat poo off the floor in the lounge. No wonder it smells." The local authority had reported this as an issue when they visited the premises two days previously. Their feedback included the following comment, 'There was a strong smell, and the office smelt strongly of cat urine.' We saw no action had been taken to address this concern. This meant that people were living in an environment that was not free from odours that were unpleasant.

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

We saw that during the day there were enough staff to meet the personal care needs of the people who used the service. This was reflective of many people being independent and not requiring continuous staff presence to keep them safe. One staff member said, "As long as nothing happens, then there is enough

staff." However, we could not be sure there was enough staff during the night. For example, one staff member described a situation where they had to leave a person on their own when they were having a seizure. The staff member told us, "I was on my own and had to go upstairs to alert the manager. I didn't have access to a phone, and couldn't get help in any other way." Records we saw confirmed that this incident had taken place and that it had occurred when there would have only been one member of staff awake to support people. Following this incident the provider had not reviewed the potential risks posed to this person should the situation have occurred again. Feedback from community professionals consistently commented on there not being sufficient staff to meet all but the basic care needs of people who used the service. One community professional stated, 'They do not provide adequate supervision for the clients and this has resulted in harm on a number of occasions.'

We were not confident that staff had personal protective equipment (PPE) readily available to them if they required it. PPE should be used routinely when supporting people with their personal care. We saw that no protective gloves were available for staff to use when they were in the toilets or bathrooms. This meant that staff would not have easy access to them when needed. Staff told us they were not always able to access PPE. One staff member told us, "I had to buy my own gloves as there weren't any available. There have been quite a few times when I've only had the one pair to use for everyone. It's just not right. The manager said we were using too many." The senior commented, "I know that some people have brought their own gloves, but there are spares in the office." We asked the provider to share information to confirm how their stock of PPE was monitored and how often this was ordered. At the time of issuing the draft report on 20 December 2016 this information has not been provided to us. This meant we could not be sure the provider ensured staff had sufficient supplies of PPE available to them.

The staff were aware of how to safeguard people but we were not confident that incidents had been reported and if all concerns were raised. For example, one staff member told us, "I noticed bruising to one person and I completed a body map and noted my concerns in the communication book." We saw that this issue had not been raised with the relevant authorities by the provider. This meant we were not confident that any other concerns had been raised.

We saw that risks to individuals had not always been reviewed in a timely manner. For example, we saw that one person had experienced two seizures within the last four months, both before the day staff were on duty. Their information had not been updated and the advice to night staff was to 'monitor and record.' There was no information that stated what they should do if the person had a seizure. This meant that staff did not have the information needed to support the person or minimise this risk. The deputy manager told us, "There is advice in the laundry room, it's general information for all. We got it off the internet." This meant that the risks to individuals had not always been considered and the risk assessments did not reflect the individual person's specific needs.

Staff told us they had received training to help them protect people from harm. One staff member said, "We had the training booklet to work through." Staff we spoke with were knowledgeable about the different types of abuse that could happen. Staff were able to describe the signs they would look out for that may indicate people were being abused. One staff member said, "A person may shy away, flinch or may become withdrawn." Another staff member told us, "We would look out for any bruising." Staff were aware of the process to follow if they had any concerns. One staff member told us, "I would record any concerns I had and would raise the issue with one of the management team."

People were supported to take their medicines. One person told us, "I have my tablets every day. One in the morning; then after lunch and two before I go to bed. The manager gets them for me and makes sure I've had them." We saw that people's medicines were stored in a safe place and the stock levels we checked

were correct. However, one person had been prescribed some short term medicines. The provider had handwritten the name of the medicine on the medicines administration record but had not stated the dose and when the medicine should have been given. This meant the person was at risk of not having their medicine as prescribed.

Inadequate

Is the service effective?

Our findings

At our previous inspection, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Even though general capacity assessments had been completed, these did not relate to a specific decision. There was also no evidence as to how decisions had been made in people's best interests. We issued the provider with a requirement notice and told them to put actions in place to ensure they were meeting this regulation. At this inspection, we saw that some improvements had been made. In the records we looked at, we saw that people's capacity had been considered and that best interest decisions had been made regarding various aspects of their care. However, further improvements were required. For example, there was no specific decision identified for the capacity assessment to be based on. This demonstrated that the provider still did not show an understanding about the Mental Capacity Act 2005 (MCA) and meant they were still not acting within the principles of the Act.

The MCA provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).

We checked whether any conditions on authorisations to deprive a person of their liberty were being met. An application had been submitted to the local authority for one person who was seen to be restricted. Staff were not aware of this and no measures had been put in place whilst they waited for the outcome of this assessment. One staff member said, "Things like that are not discussed with us." This demonstrated the provider had not considered the need for staff to know how to support people under the MCA.

Our previous inspection found whilst the provider was not in breach of any regulations, there were aspects of care that needed improving to ensure that people had greater choices in their meals and had easier access to drinks. At this inspection, we found that few improvements had been made. People did not have easy access to drinks. We observed one person sit in the dining area for nearly two hours after getting up without a drink. Other people were waiting for over an hour. No one was offered a drink until the breakfast was served. When people received their drinks, they drank them very quickly, and one person was heard to say, "Oh, that's better." When people were offered a drink, they were not given a choice. People told us that drinks were only available at set times during the day.

People were not actively supported to make choices about their meals. Comments from people who used the service included, "I have for breakfast what the staff put out." "We always have white toast." And, "We always have sandwiches or something on toast for tea. The manager gets that for us." Another person said, "The staff choose what's on the menu; we don't choose." And "I think we could ask for something different, but we don't." We saw that people were offered limited choices for their meals. One staff member told us,

"Some people really like chips, but it's very rare that they get them." Feedback from a community professional stated, 'People's dietary needs are met, but there is little or no choice. I am not aware of them being involved in menu planning or shopping for the weekly food.' We were told that the mealtimes were not flexible, and one person said, "All our meals and drinks are at the same time." This demonstrated that people were still not involved with decisions about their food and drinks.

We saw that typed menu cards had been introduced however, these were not suitable for all the people who lived there. One person commented, "I don't know what we've got for lunch today." This demonstrated that the menu cards were not in a format that everyone could understand and were not accessible to all. People did tell us they enjoyed the meals and one person said, "We like the food here."

We found people's healthcare needs were not responded to in a consistent manner. One person told us, "I usually have a flu injection, but I haven't had it yet. I don't know if I'll get it." We checked advice from the NHS, which stated the best time for people to have this vaccine was from the beginning of October to early November. This meant that people may not have had the full benefit of this vaccine if it was administered late.

We found the provider did not always respond to people's changing health care needs in a timely manner. Professionals we spoke with offered us the following feedback, 'I was very concerned that the staff did not seek medical advice or attention for one person's pressure sores until they had deteriorated. I believe that their practice was unsafe in dressing the pressure sores themselves without seeking medical attention in a timely manner.' Another community professional commented, 'The clients who live there are ageing with increasing health needs. I feel there is a failure to recognise the changing needs of individuals.' This community professional added, 'They are misguided in their approach and have a 'we can manage' attitude instead of seeking professional support on occasions, and this has resulted in harm or risk of harm.'

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received an induction when they started working at the home. One staff member told us, "I worked a day shift with someone, and then covered a night shift with someone as well. I was told that if I didn't feel ready, I could do more with others, but I was fine." This enabled staff to develop their knowledge of people in order to meet their needs. Training was available for staff, and one staff member commented, "We did moving and handling training as a group; other training is through work books that you read and answer questions. These are sent off for marking." Another staff member said, "A lot of our training is done by using the workbooks, which is fine for some things. But I learnt more and took a lot more in when we had the group training about diabetes." Staff were supervised by the senior carer, and one staff member told us, "I do have supervision with the senior, and can raise issues about the people that live here with them." This meant staff were given some opportunities to discuss their work and roles.

Inadequate

Is the service caring?

Our findings

People's dignity was not always promoted. One person told us, "You've got to ask for toilet paper; they keep it in the office. The manager or deputy will give it out. I couldn't help myself; that would be rude. You have to ask permission." We saw that two of the three toilets upstairs did not have toilet paper. One staff member said, "It's not dignified for people; I've seen people with soiled clothing as they have not been able to clean themselves properly after going to the toilet." Another staff member commented, "I was told off by the manager as I'd put one person in clean clothes but their bath day was the next day. People don't always have clean clothes to wear. Often people will be wearing the same clothes for five or six days." The local authority had reported that when they had visited on two consecutive days, one person was seen to be wearing the same soiled clothing on both occasions. This demonstrated that people were not treated in a respectful manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not actively involved in making decisions about their care. One person told us, "I always change my bed on a certain day; you can't have a different day as that's someone else's. I have a bath on a certain morning. I've not been asked if I would like a different day." Another person said, "The manager knows what I like and don't like; sometimes they decide what I like." One staff member told us, "I was given a list of who I had to get up in the morning, so people didn't really have a choice. Some people will indicate they don't want to get up, but they still have to." Another staff member commented, "Even people who could make decisions for themselves aren't supported or encouraged to do this. Everything is based on the routines in place, and people don't really have any choices." People were not supported to make choices about their clothing. One person said, "The manager buys our clothes." Another person told us, "These clothes were here, they were given to me. I've not been to the shops to buy my clothes. I don't know where my clothes come from." This demonstrated that people did not have choice and control in their lives.

Some people's independence was promoted. One person told us, "I've got a bus pass and can get to places myself. I wash and dress myself, and change my bed clothes once a week." Another person said, "I like helping out once a week when I hang the washing out." We saw that people's privacy was respected. We observed staff ask people discreetly if they needed to go to the toilet, and we observed staff knock on people's bedroom doors before entering. People told us that the staff caring towards them, and one person said, "You are looked after here." Another person commented, "I like the staff, they are nice to me." We heard staff speaking with people in a kind way, and found that staff knew people well.

People told us they were able to stay in contact with people who were important to them. One person said, "I'm seeing my relation at the weekend and we'll go and do some shopping." Another person commented, "My relations do visit me; I like seeing them."

Requires Improvement

Is the service responsive?

Our findings

People did not receive care that was individual to them. We saw that people were sitting in the same places and doing the same activities as they had been during our last inspection. One staff member told us, "I don't think people are treated as individuals; it's all regimented. People will sit in the same seats and do the same things day after day. It's not so bad for the ones who can get up and go out, but for others, they can't just do that. It's like the manager knows what's best for them rather than what people may want." Feedback from the local authority and community professionals consistently told us that when they visited, people were always in the same room at the same seat and all undertaking the same activities. This demonstrated that people were not receiving personalised care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had limited involvement with the planning and reviewing of their care. One person told us, "My relation made the choice for me to live here." Another person said, "The staff decide what I'm doing." One community professional commented in their feedback, 'At reviews, I have had to request that the person is asked if they would like to attend. It was taken that due to them not being able to communicate verbally they were not needed to attend.' This meant people were not supported to be involved in the planning of their care.

People told us about the activities they accessed; however, we found that their opportunities were somewhat limited. One person said, "I do voluntary work twice a week, and also go dancing one afternoon. I like going out and meeting people. I like doing the word search books here." Another person commented, "I like to listen to music in my room." We saw that there were homemade decorations on display. . Other people told us, "I do like to go out in the garden in the summer, but I've not done a lot here." Another person said, "The three of us always go to the shop down the road with the senior on the same day once a week." We were told about activities that people would like to do, but had not been able to. For example, one person said they would like to see their favourite band, and another told us how they used to go to the seaside but had not done this for some years. One community professional commented in their feedback, 'One person told me that they were all going out together for an event and question if people had an alternative choice.' Another community professional told us, 'I am concerned about the levels of activities and the opportunities available for meaningful engagement within and outside of the home.'

We saw that some people's care records contained information that was personal to them such as a 'one page profile'. Some people told us they were aware of their care plans and knew they were kept in the office. However, some people's information was not included. For example, one person had limited verbal communication but was able to indicate if they needed to use the toilet. This information had not been detailed in their care plan. This meant that staff may not have responded when the person communicated their needs. The local authority found that some records needed updating. For example, one person's records had been reviewed in the summer, and stated 'No change, remains in good health.' An event had happened in this person's life five years previously, however the records did not reflect this. This meant that

staff did not have current information to help them support the people who used the service. Staff told us that people's care plans were locked in the office which they did not have access to at certain times. When we arrived to carry out the inspection, we found the office door was locked. One staff member told us, "I didn't know the protocol to follow for one person as I couldn't look at the care plan." This meant that staff did not have access to important information that would enable them to provide the right support for people.

People who used the service had some opportunities to share their views. One person told us, "We have a meeting with the senior once a month. We talked about helping out and getting on with each other. We also talked about things we were going to do at home, and then we made some cards." People told us they knew how to make a complaint. One person said, "I would speak to the manager. She's in charge." There was a complaints leaflet displayed that advised people and their relatives how they could raise concerns.

Inadequate

Is the service well-led?

Our findings

Our previous inspection found that whilst the provider was not in breach of any regulations, the leadership and governance in place needed improvement. We accounted for this in our last report. At this inspection, we found that the required improvements had not been made.

We have inspected this location on five separate occasions in a 20 month period. Over this timeframe, the provider has consistently been performing below the standards required. At this inspection, we found that despite concerns raised from our previous inspections and a meeting with the provider, few overall improvements had been made to the provision of the service. We have listened to concerns raised by visiting professionals and staff. Following this inspection, we have concluded that we do not have confidence in the provider to make the necessary improvements to ensure that the service provides care that is consistently safe, effective, caring, responsive and well led.

We found that the audits in place had failed to detect and respond to issues. For example, the fire checks conducted had not identified that the fire doors would not be effective in the event of a fire. The environmental audit had not identified that there was a strong smell of cat waste or that one of the person's rooms required urgent repair due to a leak. This lack of action had resulted in a significant area of the room being damaged with mould and damp. We found that when incidents had occurred, there was no effective system in place to analyse these. For example when people had a seizure their assessments had not been reviewed to reduce any further risks, and staff levels had not been considered following these events. This meant we could not be assured that provider took action to ensure people's safety or to make improvements.

We have reported previously about the culture of the service not empowering the people who live there. We found this to still be the case. Feedback from the local authority has consistently described the service as 'institutional' and 'stuck in a time warp.' Observations during our inspections have confirmed this. People who used the service were not enabled to contribute to its development. One staff member told us, "I do feel that it's very institutional here, all very regimented. The people who live here will say that they are happy, but they maybe don't know any different." Another staff member told us, "I have been told not to pander to the people who live here, but I think it's wrong not to offer someone a drink if they want one or are upset."

Staff told us that some of the management were not approachable. One staff member said, "I find the manager very overpowering." Another staff member told us, "When I have raised issues with the manager, I've felt they tend to shun things off." People were aware of the whistle blowing policy, and one staff member told us, "There is a poster up with some details, but I picked up more about it from someone who doesn't work here. It's not something that is discussed at the home." Another staff member commented, "I have found it very difficult to raise things; I did try to give the manager some information but they walked away from me. They didn't speak to me for three weeks after that." This demonstrated that a positive, open culture was not promoted.

Staff did not feel consistently supported by the management team. One staff member said, "We've only had

the one staff meeting and that was back in March. We were handed out some workbooks and asked for our ideas about activities that people may like to do, and that was it. We were never asked anything else. They certainly didn't get our input about developing things for the people who live here." Records we looked at and the registered manager confirmed that there had been no further staff meetings since March 2016. Another staff member told us, "I did ask to do my medicines training, but the manager said I couldn't. They said this was because they or the deputy did it." This demonstrated that staff were not actively involved in developing the service or their skills.

We saw the provider was asking inappropriate questions within the employment process. For example, candidates were asked for their marital status, which is a 'protected characteristic' and could be seen as discriminating against people during recruitment. The registered manager was not aware that this practice was not in line with employment law. The local authority reported that the provider was using outdated terminology within the pre-admission assessment. For example, referring to people as 'handicapped.' This demonstrated that the provider had not kept up to date with current practices.

A community professional told us that a staff member had been treating a person's pressure areas before they sought medical advice. One of the conditions of registration for Southwinds is that 'The registered provider must not provide nursing care under accommodation for persons who require nursing or personal care at Southwinds.' This meant that support was given to people which was not in line with their registration.

These all constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the provider understood their responsibilities of their registration with us. They had not notified us of significant events that they were required to report. For example, we had not received notifications regarding one person who had developed severe skin damage and the ongoing safeguarding investigation following a serious injury that occurred.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the hallway.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Commission without delay of incidents as they were required to do. Regulation 18.

The enforcement action we took:

Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people received person centred care that met their needs and reflected their preferences. Regulation 9(1).

The enforcement action we took:

Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people were treated with dignity and respect. Regulation 10(2)

The enforcement action we took:

Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that the premises was safe as fire safety procedures were not followed. Regulation 12(2)(d).

	The provider did not make arrangements to respond appropriately and in good time to people's changing needs. Regulation 12(2)(a).

The enforcement action we took:

Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was not visibly clean and free from odours that were offensive or unpleasant. Regulation 15(1)(a)

The enforcement action we took:

Notice of Proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a).

The enforcement action we took:

Notice of Proposal to cancel the providers registration.