Bedford Borough Council

Southway

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Southway is a residential care home providing personal care for up to 42 people. The service provides support to older people most of whom were living with different types of dementia. At the time of our inspection there were 40 people using the service.

People's experience of using this service and what we found

We found there were shortfalls with how the managers and provider responded to accidents and injuries. Investigations were not thorough with safeguarding referrals made to promote people's safety. Actions were not considered and taken to try and reduce the risk of the injury happening again. Risk assessments lacked details and staff did not always have clear plans to follow. There was also a lack of care planning around some people's medicines to ensure staff had all the relevant information at hand to guide their actions.

There were shortfalls with plans and drills related to fire safety. We were not confident at times there was enough staff or staff had the right support to spend time with people, talking with them and responding to them when they needed support. Parts of the home and people's rooms needed decorating, but there was no plan in place to do this.

The registered manager and provider were not carrying regular audits and checks on the quality of the care people experienced. Audits were not effective or not taking place to see what was happening in key areas and consider if changes needed to happen.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People felt happy living at the home. One person said, "No washing up, no ironing, a life of comfort. No one has upset me so far." Another person said, "Staff are nice here, its ok."

People's relatives were confident their loved ones were safe, and staff had got to know them. Relatives spoke of being made to feel welcomed by staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 1 February 2020). At this inspection we found the service had deteriorated.

Why we inspected

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to promoting people's safety and the managers quality checks on the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Southway

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Southway is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Southway is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. The inspection activity started on 22 June 2022 and ended on 4 July 2022. We visited the service on 22 June 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used the information gathered as part of monitoring activity that took place on 11 May 2022 to help plan the inspection and inform our judgements. We also reviewed the information we held about the service. We used all this information to plan our inspection.

During the inspection
We spent time in the home to understand people's experience of living at the home. We spoke with five people who lived at the home and spoke with nine people's relatives by telephone. We also spoke with ten members of staff as well as the deputy manager and registered manager.

We reviewed a series of documents and sought clarification from staff to validate the evidence found. We looked at seven people's care records and checked the medicines for six people. We reviewed three staff employment checks, and various safety plans and checks completed in relation to equipment used, COVID19, and the building, which included fire related equipment. We also reviewed audits completed by the management team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The registered manager and provider did not have a safe system and processes to respond to injuries and incidents. This put people at risk of harm.
- We found examples of when people had a bruise or cut, which were not effectively investigated. Either no investigation took place or no meaningful analysis was carried out to consider what actions needed to be taken to prevent a re-occurrence of the incident.
- As part of this analysis no one in the management team were considering if a safeguarding referral needed to be raised. Even when one person presented with a bruise and a member of staff had said it could have been caused by the hoist. This did not trigger a safeguarding referral and actions to prevent this from happening again to this or another person.
- Staff knew what potential harm could look like and they were to report it to the registered manager or senior. But most staff we spoke with did not know of who or how to report their concerns to outside of the home.
- Risk assessments for people did not fully explore the risks which people faced. Nor did they direct staff what they must do if something went wrong for a person.
- We found issues with fire drills, evacuation plans, and ensuring there was an up to date fire risk assessment in place.
- The registered manager and provider started work to address these shortfalls during the inspection process.

Using medicines safely

- Thirteen people had all been prescribed antibiotics by the GP in case they needed them. However, no one had any related care plans or protocols directing staff when these should be administered.
- There were no agreed situations in consultation with a professional when this medicine should be administered. The management team had not risk assessed this, and they were not monitoring this situation. There was a risk the antibiotic was not the right one for a potential infection and if there was something else causing the decline in the person's health.
- There was not a safe process and plan in place for those who had medicines administered via a patch, to ensure the new patch was not applied to the same area of their body.
- We also found one medicine which could not be accounted for and a member of staff had signed for a person's evening medicine in the daytime in error.
- The registered manager told us they had taken action to correct these issues and they had changed how

they monitored and audited people's medicines.

Systems had not been established to effectively assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives believed their loved ones were safe. One person's relative said, "I feel ok with the home I feel [relative's name] has been there long enough and feels very safe." Another person's relative said, "I feel [name of relative] is safe, wouldn't have them anywhere else."

Staffing and recruitment
● People spent regular periods on their own with no staff engagement. We were therefore not confident at certain times of the day, there was enough staff to promote peoples social experience at the home.
● Staff told us they felt there was enough staff to meet people's care needs. But staff told us they tried to fit in talking with people during the day or they did this when they were providing personal care or filling out records.
● The management team were not completing audits which evidenced they were assessing if they had enough staff to spend time with people.
● Staffing recruitment checks were taking place. But we found there were gaps of three and one month when the Disclosure and Baring Service (DBS) checks were completed and staff started at the home, with no other DBS update being obtained to promote people's safety with new staff. The registered manager told us this issue would be corrected in the future.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not always working within the principles of the MCA. If needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● One person had not been consulted with about their health, instead their relative had made this decision on their behalf. The principles of the MCA had not been followed. An MCA assessment had not been completed with a best interest process followed. We also needed to explain this to a senior member of staff who had not understood the principles of the MCA and its application here.
● Staff did understand the importance of offering people daily choices about their care and food.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

● The management team and provider were enabling people's relatives to visit their loved ones in a safe way. This included safe measures when individuals were isolating because they had COVID19 symptoms.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Managers and the provider did not have effective systems to robustly respond to accidents and incidents when people were harmed. Investigations were not effective or did not take place. There was no thorough oversight from the management team and provider as to what the issue was and what actions had been taken to try and rectify this.
- The information into these events which the managers gave to the provider was limited. So, the provider did not always have a full picture as to what had happened.
- Audits were not taking place to see if there was enough staff to promote people's social time at the home.
- We found issues when we looked at people's risk assessments, their medicine administrations, food diaries, fire related plans, food storage, audits, staff recruitment checks, the application of the MCA and the upkeep of the home. The manager's and provider's audits had not identified these shortfalls with plans in place to rectify these issues.
- The registered manager and provider had started to address these issues when we told them about them, but their own audits and established systems should have identified these issues.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We identified shortfalls with how staff supported some people. Staff did not respond when one person stated in an animated way, they needed support to use the bathroom. One member of staff continuously tried to put food into one person's mouth when they were dozing after lunch, even though they kept indicating to them to stop.
- Another person had been supported to bed to rest after lunch, with the curtain left hanging off the rail and bright sunlight shining into their face.
- Dementia friendly techniques were not used to help people find their bedrooms. Accessible information was not available to tell people what events were happening at the home and what food options there were at mealtimes. Although, dementia friendly colours were incorporated into the newly refurbished shower rooms.
- We did see staff supporting people to have a choice with what they wanted to eat and drink and take part in a group exercise class outside. However, further work was needed to improve people's experience of living at the home.

Working in partnership with others

● The management team had not involved other organisations and professionals relevant to some people living at the home. To consider if they could improve their experience and contribute to planning their care.
● We found examples of this with people living with dementia. For example, one person living with dementia had a particular need which staff were supporting them with, but specialist support was not sought, to check if more could be done to help this person with this need.

There were key shortfalls with how the provider and registered manager assessed the quality of the care provided at Southway. Effective systems had not been established which were used to effectively assess and monitor the standard of care at the home. This placed people at potential risk of harm in relation to their mental health and wellbeing. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives spoke well of the culture of the staff and management team. One person's relative said, "Staff are all very friendly, very willing and have been there [at the home] a long time, I feel they care for [name of relative]." Another person's relative said, "[Name of relative] accepts all the staff's help and talks about them in a fond way." A further relative told us that, "The staff are lovely, very comfortable, genuine and caring, it's a lovely home."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● There was a complaints process in place. People were asked their views of the care in questionnaires.
● When people did raise issues during the questionnaire, we were told what actions the management team took to correct these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to effectively assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were key shortfalls with how the provider and registered manager assessed the quality of the care provided at Southway. Effective systems had not been established which were used to effectively assess and monitor the standard of care at the home. This placed people at potential risk of harm.