Prime Life Limited

Seacroft Court Nursing Home

Inspection report

Seacroft Esplanade
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Seacroft Court Nursing Home is a care home providing personal and nursing care to up to 50 people. At the time of the inspection, 32 people were using the service. The service can support up to 50 people. The service provides accommodation for people on two floors.

People's experience of using this service and what we found
Risk management was poor. A lack of support plans and assessments in place meant people's needs were not identified assessed or managed effectively. Ineffective care planning led to people experiencing increased periods of distress and restrictive practices.

The service failed to protect people from poor care and abuse. Staff had failed to identify, record and report incidents, the provider had failed to monitor the quality of the service resulting in poor care and incidents of a safeguarding nature occurring.

There were indicators of a closed culture and a punitive approach used by staff. Staff had a lack of support or guidance on how to support people to lead inclusive and empowered lives.

The provider demonstrated specialised training had been delivered. However, the training needed to be implemented and embedded and further developed, to demonstrate staff knowledge and competency to improve outcomes for people.

Organisational governance and quality assurance arrangements had not been effective in monitoring and improving the quality and safety of the service. We found systemic failures with oversight and quality assurances; posing significant risk to service users.

People were not always supported to have maximum choice and control of their lives and 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 support this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 April 2023). The service is now rated inadequate. This service has been rated requires improvement for the last four consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and further risk was found.

Why we inspected
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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of behaviour, safeguarding's, accidents, and incidents. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Seacroft Court Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, safeguarding, governance and leadership at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Seacroft Court Nursing Home

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 2 inspectors.

Service and service type
Seacroft Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Seacroft Court Nursing Home 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. 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 all this information to plan our inspection.

During the inspection
During the inspection we spoke with 3 people who lived at the service, 2 care staff, the registered manager and the regional manager. We looked at 6 people's care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not kept safe from avoidable harm. Staff supporting did not always have the information of how to support the person with their behaviour, as a consequence a series of incidents had occurred resulting in injury to people, staff and damage to the environment.
- Staff and management had training on safeguarding, however, they did not know how to recognise and report abuse. We found incidents of a safeguarding nature written in the incident file . These incidents had not been reported to the relevant professional bodies, meaning these incidents could not be investigated fully.
- We found restrictive practices were used for people limiting their freedoms. For example, daily notes had recorded, "[Staff] had to hold [Person] wrists to restrain them." We found there were no risk assessments or support plans in place related to the use of restraint or restrictive practices. Furthermore, we found no evidence of incidents recorded when restraint or restrictive practices were used.
- We found further indicators of restrictive practices. The care plan stated, 'Staff have to intervene in his best interest to prevent skin breakdown'. There were no details or information for staff to understand what 'Intervene' means for escalation of behaviour or whether or not physical intervention can be used.
- There were indicators of a closed culture at the service where punitive measures were used to manage people's distressed behaviour. We reviewed daily notes and found that staff were potentially using restrictive interventions without appropriate care plans and authorisations, as detailed above. Furthermore, during discussions with the registered manager we were told. "We have to coerce [Person] into doing things". This indicates a culture of control where staff have power over service users.

Systems were not robust enough to demonstrate people were safeguarded, this placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- During our inspection we found the registered manager and provider had failed to properly assess and mitigate a wide range of potential risks to people's safety and welfare, in areas including behaviour management, safeguarding, accidents and incidents and organisational learning.
- People's risks were not managed. We found minimal information in care plans. Some risk assessments were not relevant to people's current and ongoing needs, we also found no care plans or risk assessments in place for people who presented significant risk to themselves or others. This meant people's risk were not assessed, monitored or managed effectively, leading to poor care and unwarranted restrictions for people.
- People and staff were not protected from other people's behaviour. Records showed people had received injuries as a result of poorly managed behaviour. Harm was caused to other people, staff and property was

damaged. Furthermore, there were no risk assessments in place in relation to the persons behaviour. Inadequate systems and processes failed to assess and manage behaviours placing people and staff at significant risk of harm.
● We found inadequate de-escalation strategies for people who presented with distressed behaviours. For example, a care plan stated, "Let's talk about your interest", however, the care plan fails to state what the persons interests were. This meant staff were not fully informed of distraction techniques or triggers to prevent escalation for the person.

Learning lessons when things go wrong
● There was no evidence of learning from incidents. Documents showed there were 91 incidents of distressed behaviour involving one person. Incidents included damage to property, sexualised behaviour and physical aggression towards people and staff.
● Another person had multiple incidents detailed in their ABC documents, including physical and verbal aggression to people and staff, attempting to abscond and expressing they wished to take their own life. These incidents had not been reviewed and care plans updated to guide staff how they should support the person.
● The registered manager told us they were not always aware of incidents, furthermore, due to the registered manager and providers failure to ensure incidents were reviewed and referred appropriately, we found evidence incidents reoccurrence and with more severity, resulting in actual harm to people.

The provider failed to assess, manage and monitor risks relating to risk management, accident and incidents and behaviour management. This placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
● The service had recently put in place Positive Behaviour Support (PBS) training; however, this training had only taken place 2 weeks prior to the inspection. Evaluation sheets staff completed following the training asking what they had learned, stated, "PBS", "All of training" and "How to fill out a chart correctly". The provider and registered manager needed to embed and implement the PBS training, ensuring staff demonstrated competency and knowledge when supporting people.
● The regional manager informed us staff who delivered care may not have the understanding or knowledge of restrictive practices, and we found restrictive practices were used by staff. Meaning people did not have their human rights supported or respected. Issues identified during inspection demonstrated staff lacked

knowledge in regards of understanding risk management, behaviour management and communication leading to people being at risk.
● We found enough staff deployed and in line with the provider agreed staffing levels. We found staff supporting did not always have the required skills to meet the needs of people, despite this the provider allocated these staff to support, placing people at risk of poor care.

Using medicines safely
● Medicines were managed safely. We found the use of antipsychotics had been assessed and managed appropriately. Some people required occasional medicine on an 'as needed' basis. We saw staff had clear guidance on what symptoms the person might show and how this medicine should then be administered.
● We reviewed medicines administration records charts [MAR} were completed correctly. Staff providing support had the required training.

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 supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
We have no concerns with visiting at the care home.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We found indicators of a closed culture within the service, due to unlawful use of restrictive practices and the use of punitive language, additionally, the lack of manager and provider oversight led to a decline in care standards delivered to people
- Management had failed to ensure people's needs could be meet. Admissions had been accepted, when it was clear the service did not have the adequate skills and competency to support people, this meant people were at risk and had their care impacted, due to inadequate support.
- People were exposed to poor outcomes and at significant risk of injury, due to the providers inability to manage behaviour effectively, and take timely action to monitor and mitigate risks.

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; Continuous learning and improving care

- Regulatory requires had not been met by the provider, we found we had not been notified regarding several incidents. The service is legally required to notify us of incidents of this nature
- The provider had also failed to monitor the performance of the management and senior team at Seacroft Court Nursing Home. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.
- The provider had failed to be open and honest. We found due to a lack of oversight the provider had failed to identify incidents that had placed people at risk of harm. Consequently, the provider had failed to notify the relevant professional bodies when appropriate and failed to investigate incidents effectively.
- The last 4 inspections were rated 'requires improvement' in well-led. The provider has consistently failed to make adequate improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Some governance processes were ineffective. A lack of oversight at the service and provider level meant the quality and safety of the service had declined. We found no effective monitoring in place, which resulted in poor care and people subjected to physical harm.
- Organisational governance and quality monitoring systems had failed in assessing, monitoring and mitigating potential risks to people's safety, as evidenced by not identifying accident and incident issues, safeguarding incidents and inadequate behaviour management. We found no systems in place to monitor

the safety and effectiveness of service provision. The failure to have these in place significantly restricted the ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.

Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The registered manager and provider had not always worked collaboratively with health and social care professionals to ensure people were safe and received care which met their needs. Has detailed above in 'Safe' the provider did not always report incidents to the relevant agencies or seek professional advice to ensure care plans were accurate and reflective or the person's needs. We found external professionals' involvement was often when people were in crisis and distressing intervention was required.
- The registered manager told us they are mainly receiving referrals for people with high needs and complex behaviours, there is a pressure to fill beds by the provider but is trying to balance risk. However, people had still been admitted to the home when their needs could not be met. This posed a risk and directly impacted on them, other people and staff.
- At the last inspection we reported no concerns in regards of engagement with people and relatives. At this inspection we found the same and no additional concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess, manage and monitor risks relating to risk management, accident and incidents and behaviour management.

The enforcement action we took:

Notice of Proposal to Impose Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not robust enough to demonstrate people were safeguarded, this placed people at risk of harm.

The enforcement action we took:

Notice of Proposal to Impose Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm.

The enforcement action we took:

Notice of Proposal to Impose Conditions