Isle of Wight Council

Seagulls

Inspection report

Witbank Gardens
Shanklin
Isle of Wight
PO37 7JE

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11 January 2018
12 January 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 January 2018 and was unannounced. One inspector and an inspection manager carried out the inspection.

Seagulls is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Seagulls is a local authority run care home which provides accommodation for up to six people with learning disabilities and Autism who need support with their personal care. At the time of our inspection there were five people living in the home.

The home was arranged over two floors with most of the bedroom accommodation on the first floor. There were bathrooms available to people on each floor. There were 2 communal areas in the home, which were a kitchen/dining room and a lounge.

The home had a registered manager. 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.

The last comprehensive inspection of this service was in October 2015 when the service was rated Good. At this comprehensive inspection we found the service was not meeting legal requirements and required improvements in the service which was delivered.

Failures to provide safe and care and treatment, person centred care, good governance and failing to act in accordance with the Mental Capacity Act 2005 were common themes.

Quality assurance systems were not robust to monitor and review the quality of the service which was provided. These had not been used effectively to identify concerns we found or drive improvement in the service.

Records of the assessment of people's ability to make some informed decisions had been undertaken. However, the principles of the Mental Capacity Act 2005 were not being applied in respect of best interest decisions to provide care or use restrictive practices. Staff we spoke with had a variable understanding of the Mental Capacity Act 2005.

Care plans were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a safe way. Risk assessments that related to people's health and safety did not ensure that all risks were effectively assessed. Action had not always been taken to reduce identified risks to ensure the

safety of people. This exposed people to a risk of neglect and unsafe or inappropriate care or treatment. Risk assessments were not being developed to promote independence and we saw that people were being unlawfully restricted from areas of the home in order to manage risks.

People and their relatives were not regularly involved in the assessment and the on-going reviews of their care. Care plans were not written in a way that would enable people to understand and be involved in decision-making.

The premises were not always well maintained. The registered manager had requested that the landlord carry out some works but this had not been done. One area of the home was not clean and did not provide adequate personal hygiene equipment for people. Following our inspection action was taken to address this.

Staff had not received the appropriate training, professional development and supervision to be able to support people safely.

Staff were task orientated and there were not enough staff to meet people's needs and to enable them to engage with people and support them to be involved in the tasks of daily life.
People received their medicines as prescribed. However, we identified some areas where improvements could be made to ensure the safe administration of topical creams.

Staff received training; however, some training to meet specific needs had not been provided. Staff had not always received regular and meaningful supervision. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

Recruitment procedures were not always safe. We saw that not all of the appropriate checks, such as references had been completed before staff started working with people.

People and their families told us they felt safe living at the home. Staff understood their roles and responsibilities to safeguard people from the risk of harm. Staff knew how to identify, prevent and report abuse.

Plans were in place to deal with foreseeable emergencies such as fire risk; staff we spoke with said they had had received training to manage such situations safely.

People were supported to maintain their health and well-being. Staff supported people to attend appointments with healthcare professionals. People were encouraged to eat healthily and staff made sure people had enough to eat and drink. However, people were not consistently being supported to be involved in choosing and preparing food and drinks.

Staff ensured people's privacy was maintained. People were not always encouraged to make decisions about how their care was provided. Staff's understanding of people's needs and preferences was based on familiarity.

We received some positive feedback about the care staff and their approach with people using the service. People were supported to take part in some activities within the local community. However, we observed occasions when staff had little time to spend with people and the care provided was task orientated.

Relatives and external health professionals we spoke with were positive about the service people received

and people's visitors were welcomed.

There was a complaints procedure in place to enable people to raise complaints about the service. However, complaints were not being captured and information was not presented to people in a way they could understand.

People, their relatives felt confident to approach the staff or registered manager and felt they would be listened to.

We identified that the provider was in breach of six of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Registration Regulations 2009. You can see at the end of this report the action we have asked to provider to take.

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.

Infection control risks were not always managed safety.

Effective hygiene was not being maintained which could result in the spread of infection.

Risks to people's health and safety had not been assessed robustly, which put people at risk of harm.

There were not enough staff deployed to keep people safe and promote their independence.

Safe recruitment procedures were not always in place and not all pre-employment checks had been undertaken.

People and their families felt the home was safe.

Staff were aware of their responsibilities to safeguard people.

Oral medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow legislation designed to protect people's rights and freedom and staff and management lacked understanding of The Mental Capacity Act.

Staff were not provided with appropriate training, supervision and appraisals from the management team.

People had enough to eat and drink however they were not always involved in making informed choices in relation to what they had to eat.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always given the opportunity to make choices and be actively involved in their care.

People were not always treated with dignity and respect.

Confidential information was not always kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had been developed, but these had not been reviewed regularly with the involvement from people and their families.

People were always not supported to be actively involved in their lives and were not always provided with regular meaningful and person centred activities.

People had mixed views about whether they were empowered to make day to day choices.

Some staff had received training in end of life care however people's end of life wishes were not recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to provide support to the registered manager to enable them to manage the service effectively.

A quality assurance process was in place, however, this had not identified the areas of concerns we found.

People and their relatives felt the home was good, however they were not asked for their views about the service by the registered manager.

There was an open culture within the home and staff told us they felt able to raise concerns. All of the policies were appropriate for the type of service.

Staff understood their roles, were motivated and felt valued by the registered manager.

Seagulls

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 took place on 11 and 12 January 2018 and was unannounced. The inspection was undertaken by one inspector and an inspection manager.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events, which the service is required to send us by law.

We spoke to one person living at Seagulls. Other people who live at the home were unable to verbally communicate with us due to their learning disabilities. We observed care and support being delivered in communal areas of the home.

We spoke with four family members and three external professionals. We looked at care plans and associated records for three people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in October 2015 when it was rated as Good.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Seagulls. One person said, "Yes, I feel safe here, it's my home." A relative told us, "We know [name] is safely looked after." Although people told us they felt safe, we were concerned about risks to them in the environment as not all environmental risks had been assessed or acted upon.

Infection control risks were not always managed safety. On the first day of the inspection we saw that people did not have easy access to toilet paper, there was no soap available for people to wash their hands and a cotton hand towel was used for people to dry their hands on. This meant that effective hand hygiene could not be maintained which could result in the spread of infection. Best practice would be to provide disposable paper towels for people to dry their hands on as germs can accumulate on towels and be passed from one person to another. The registered manager told us they used a cotton towel and the toilet paper was in a cupboard because there had been incidents when people had blocked the toilet. Alternative options for meeting the needs of the people at Seagulls had not been considered. We discussed this with the registered manager and provider's representative, who acted immediately and ordered suitable equipment to enable soap, paper towels and toilet paper to be available to all people and staff at Seagulls.

We saw that care staff were using personal protective equipment (PPE), such as gloves and aprons at times. However, we saw that one person's risk assessment stated that they needed to use PPE when carrying out a specific task; we saw that PPE was not being used by the person and they were not being supervised by the staff as specified in the person's risk assessment. Following the completion of the task staff did not prompt the person to wash their hands and maintain hygiene within the home.

The provider had an infection control policy, which detailed the relevant infection control issues and guidance for staff. During this inspection, we found the communal areas of the home such as the living room, the kitchen, and people's bedrooms were clean and appropriately maintained. There were daily cleaning schedules and care staff were responsible for carrying out the cleaning duties within the home. However, we found the bathrooms to be in need of some repair, one bathroom had cracked tiles and the flooring was lifting up. This meant that staff were unable to thoroughly clean areas and this would create an infection risk. The Department of Health published a code of practice on the prevention and control of infections in 2015. This informs providers of health and social care of the standards that must be met in care homes. We spoke to the registered manager about the concerns we had found and asked if they were aware of the guidance available . The registered manager told us that they were not aware of the updated guidelines available but had made a request to the proprietor of the building for repairs in the bathroom but these had not yet been carried out.

Staff told us that due to familiarity they were aware of the risks affecting people, their changing health needs and how to meet them. A family member said, "We know [person] is safely looked after." However, we found that risks to people's health and safety had not been assessed robustly. We saw that some peoples risk assessments were out of date and some provided little information. For example, information in one person's care plan said that they had a diagnosis of epilepsy. However, there was no risk assessment in the person's care plan to identify what the risks might be for this person and what action the staff take in the

event of a seizure. This meant that staff would not have the documentation or guidelines needed to ensure this person was safe. For another person there was no risk assessment in place for when over the counter medicines were purchased that had placed them at risk. There had been previous incidents where the person had taken medication incorrectly which might have placed them at risk. We also found environmental risk assessments relating to the service and individuals that were not being adhered to or which had been properly assessed in relation to people's rights; there is more information about this in the effective section of this report. We discussed this with the registered manager who agreed to review all people's risk assessments as a matter of urgency.

Health and safety checks were carried out. Fire checks and daytime fire evacuation drills had taken place. There were policies and procedures in the event of a fire and each person had a personal emergency evacuation plan (PEEP) to ensure their support needs were identified in an emergency situation. However, robust safety arrangements were not in place to ensure people would always be safe at night and that staff were able to raise the alarm if they felt unsafe and needed assistance. The registered manager could not demonstrate that one staff member at night could safely support all people and evacuate them from the building if required to do. The risk assessments to assess how each person may react at night if there was a fire, did not demonstrate how one staff member could safely move people out of the building without putting anyone at an unacceptable risk of harm. Furthermore, consideration had not been given to people who were subject to deprivation of liberty safeguards (DoLS) and how they would be safely supported when outside of the building.'

There was a system for the registered manager to report any incidents or accidents to the provider through an electronic record system. The registered manager told us that there had been no accidents or incidents involving people at Seagulls in the last year. 'However, during the inspection we saw that safeguarding referrals had been made following incidents in the last year. We were unable to assess what had happened in these incidents, as records had not been made of what action staff had taken to avoid a reoccurrence.

We found that although safeguarding incidents had been appropriately reported to the local safeguarding authority, no risk assessments had been reviewed or undertaken following incidents to identify any potential on-going risk. For example, when one person struck out at another person no risk assessment was carried out to determine the potential causes and consider ways that the staff could prevent a reoccurrence.

The failure to prevent and control the risk of infection and the failure to assess and mitigate risks to people's health and safety were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not sufficient numbers of staff available to keep people safe, support people to be independent and provide person centred care.

There was a duty roster system in place which detailed the planned cover for the home. The registered manager told us that short-term staff absences were usually covered by the existing staff team. The staff team were very well established, with most having worked at Seagulls for a number of years. The registered manager said that if the home needed to use staff from external sources they would seek to use staff who work for the provider elsewhere, before any external agency is contacted. We found however that people's needs were not being met due to a lack of staff.

There were two members of staff available to people throughout the day however, the care they provided was task orientated. The staff duties involved cleaning, preparing food and administering medicines. This resulted in people's movements being restricted to keep them safe. For example, people were unable to

access some areas of the home at certain times due to lack of staff availability. We observed staff encouraging people to move away from the kitchen and bathrooms when they were carrying cooking or cleaning. Staff were not supporting people to participate or be involved in tasks that would require supervision and therefore people were sat with little to do for periods of time.

Staff were task orientated and did not spend time with people unless they were providing care. For example on the second day of the inspection, we observed one person sat on their own for several hours in the lounge with no staff interaction or opportunity to engage in an activity. Games and other objects had been left on the table where the person was sat. However, they would have required support to engage with these. This meant that the person was left with little to do and no interaction for a long period time. Later on at the handover between shifts, staff reported about this person that, "Nothing has gone on with [person] today." Another person spent time looking at a magazine for a long period of time whilst staff carried out other tasks such as cleaning. We also observed staff encouraging people to stay out of the kitchen area whilst they cleaned and undertook tasks. People were not involved or were prevented from being involved as staff attempted to undertake their tasks as expediently as possible.

One person had been assessed as needing additional support for an agreed number of hours each week. This need had been agreed with the involvement of external social care and health professionals. When we looked at the person's care plan and other records held within the home, we saw that the person frequently did not have the assessed level of support agreed. This meant that the person was not receiving the assessed support as stated in their care plan. We discussed this with the registered manager who told us that they relied on existing staff to cover the additional hours required for this person and therefore it is not always possible to cover. The registered manager also told us that the person might not need this additional support anymore. However, there was no record of any review or discussion to re-assess the person's needs or changes to their care plan.

The failure to provide sufficient staff to meet identified care needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy. Staff and the registered manager had received safeguarding training and staff told us they knew how to raise safety concerns and understood their responsibility to keep people safe from abuse. The staff we spoke to gave appropriate responses to discussions about keeping people safe and reporting any concerns or incidents. We saw that a number of safeguarding concerns had been raised with the local authority safeguarding team over the last year.

Providers are required by law to notify CQC of significant allegations that occur in registered services. The provider had not done this. There is more detail with regards to this in the well led section of the report.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's business support team in conjunction with the registered manager. We looked at recruitments records for three staff and saw that not all of the appropriate checks, such as references had been completed. One staff recruitment file only had one reference and did not have details of their previous employment history. This meant that the provider could not be assured that the people they employed were suitable to work with people who use care and support services. Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people being employed. The staff we spoke with confirmed that they had not been able to start work until all of their checks had been completed. Issues in relation to the recruitment process were discussed with the provider's representative who agreed to ensure that all appropriate information was contained within staff recruitment

files and sought to ensure that all references were within the files.

People were supported by staff who had received medicines training. Medicines administration records (MAR) were completed correctly. The MAR chart provided a record of which medicines were prescribed to a person and when they were given. Staff administering medicines initialled the MAR chart to confirm the person had received their medicine. Each person's MAR had a sheet with a photograph of the person, information about any allergies and a description of how each person likes to be supported when taking medicines. Staff made regular checks of the MARs to make sure people had received their medicines correctly. People who needed 'as required' (PRN) medicines had information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. However, one person had been prescribed PRN medicine for agitation, although we were told that they no longer required this. No guidance was seen that informed staff about how to support the person prior to the need to give the PRN medicine.

Safe systems were not always in place for people who had been prescribed topical creams as not all of these contained labels with opening and expiry dates. This meant staff were not aware of the expiration date of the item when the cream would no longer be safe to use.

There were suitable systems in place to ensure the safe storage and disposal of medicines. Seagulls did not have any medicines stored that needed additional security but we saw that should they have these, safe storage facilities were available. There was a medicine stock management system in place to ensure repeat prescriptions were ordered when needed and that unwanted medicines were disposed of safely.

Requires Improvement

Is the service effective?

Our findings

At our inspection in October 2015, we recommended that the provider seek advice and guidance on adopting the latest best practice guidance in respect of recording mental capacity assessments for people living with a cognitive impairment.

At this inspection, we found that this recommendation had not been embedded in practice and the principles of The Mental Capacity Act 2005 were not being followed in line with legislation and guidance.

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 Act 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's capacity to make decisions had been assessed. Some people had been assessed as lacking the capacity to make specific decisions. During the care planning process, staff had made decisions on their behalf. These included decisions relating to the care and support people received, and the administration of their medicines. However, these decisions had not been recorded to demonstrate why they were in people's best interests. Therefore, we could not be assured that the staff and the registered manager had sufficient understanding of the MCA and their responsibilities.

The failure to meet the requirements of the Mental Capacity Act 2005 by recording decisions made in the best interests of people, who lack capacity, is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we checked whether the service was working within the principles of the MCA, and whether DoLS applications had been made appropriately. We found the provider had made , DoLS applications for some people at Seagulls. These were awaiting assessment and approval by the local authority. However, unauthorised restrictions were being placed on people within the home and less restricted measures had not been considered.

On the first day of inspection, we saw signs in the kitchen that indicated that staff should unplug equipment and restrict the use of kitchen equipment and access to food to people living in the home when staff were not in the immediate vicinity. We also observed a stable door type barrier across the entrance to the kitchen area. We asked staff and the management team why the barrier was in place. We were given conflicting accounts for the reasons for using the door and how peoples' rights were managed. Some staff said the barrier was not used and that restriction to the equipment and the use of the barrier were considerations that they had recently been discussing but not using. This was at odds with the signs in the kitchen which told staff to unplug equipment so that it could not be used by people and risk assessments for the kitchen environment produced in November 2017, which stated the same, as did staff meeting minutes from the same period. Other staff reported that the barrier was in use when they were unable to monitor particular

people in the home as these people had a tendency to overeat or look into the bin for food. Further to this, we also saw a risk assessment for one individual, which was dated from 2016, which stated that the barrier should be used to prevent the person from accessing the kitchen.

We were concerned that senior management had failed to recognise that they were potentially restraining people without authorisation and had seen this as an appropriate restriction. There were also no best interests' considerations or any Deprivation of Liberty Safeguards (DoLS) applications with regard to these restrictions.

The failure to ensure that lawful authority was obtained before people were deprived of their liberty for the purpose of receiving care or treatment is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of the staff at Seagulls had worked there for several years. We spoke to two staff members during the inspection, who both confirmed that they had received induction training and had completed a number of shifts shadowing an experienced staff member, before they worked alone with people. We saw that staff had relevant qualifications such as National Vocational Qualifications (NVQ's) in health and care or The Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us that new staff received the provider's induction and if they had not already achieved it, would undertake the Care Certificate. Staff we spoke with said they felt well supported and could ask the registered manager for support.

Staff were supported through the provider's mandatory training programme, which included safeguarding, fire safety, first aid, infection control and moving and handling training. The provider's representative for the service showed us the staff training record matrix that was in place. This identified the training that staff had completed and when further training was needed and was kept up to date. In addition to this, some staff had training provided by an external educator to develop more specialist knowledge such as dementia, learning disability and mental health. However, we saw that some training that had been identified to manage risks and to meet the needs of people had not been delivered. For example, it was identified that staff needed training to support them to manage behaviour that challenges and this had not been provided, despite staff requesting this training help them support people.

Staff supervisions were not as frequent as directed by the registered manager who told us that staff should receive supervision 'every eight weeks, around six a year'. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. We looked at three staff supervision records, we found that one staff member had received one supervision in 2017, the second member of staff had received two supervisions in 2017 and the third member of staff had received four supervisions in 2017. The registered manager had failed to ensure all staff received appropriate supervisions and the opportunity to discuss their development and any concerns in a timely and structured way.

The failure to provide appropriate training , supervision and appraisals is a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with suitable and nutritious food and drink. Staff told us that they know what food people liked and disliked and the menus were developed by staff with this in mind. Staff were aware of individual food preferences through familiarity, but this information was not recorded in people's care plans. Some people were unable to verbally communicate their food or drink choices. Choices were not presented to people in a way that would support them, such as using pictures or symbols. Staff told us that there are plans to introduce a new system using pictures and symbols to enable choice. We refer further to

people's choice and communication needs in the responsive section of this report.

People's general health was monitored. The registered manager was aware of how to contact health professionals, such as GPs, community nurses and chiropodists and they were involved in people's care where necessary. An external health professional told us, "There was good engagement between the staff, the person and their family, with a focus on them being present and involved with health reviews and decisions made, despite their very limited communication." However, we found that despite positive comments from external professionals, reviews and involvement with external professionals was not always recorded in people's care plans. This meant that the home was unable to track changing needs and any associated risks and to evidence any actions they had taken.

People's needs were not always met by the adaptation, design and decoration of premises. For example, there were a number of areas in the home which needed decorating including the replacement of flooring and tiling in one bathroom. The registered manager told us that a request has been made to the housing association who owns the building, for a new bathroom with accessible shower facilities. This is because it had been identified on a recent holiday with people, that they had really enjoyed the 'wet room' and had enabled some people to be more independent when showering. The registered manager was aware of repair and decoration needed throughout the home and told us that a request for this work had been made to the provider. However, there was no agreed date for when the work would be carried out.

Requires Improvement

Is the service caring?

Our findings

Family members told us they thought that the staff were caring at Seagulls. Comments included, "All the staff are great, we are so happy that [person] has their support" and "They are doing their best and are a very cohesive group." The atmosphere was relaxed and friendly. Relationships with staff had developed over time with a well-established staff team. A family member told us, "The care [person] has had from the staff at Seagulls has been fabulous, we are so happy [person], has their support and the staff know them well." A second family member said, "They [staff] are like a family, they are all great." People appeared relaxed around staff.

Although family members spoke positively about the care that people received, we observed throughout the inspection that people were not always given the opportunity to answer for themselves and staff had a tendency to answer for people. For example, when we asked one person about a task they had just completed a staff member quickly answered for them. We also saw information in care files and risk assessments that people should be prevented from accessing the kitchen (further information about this can be found in the effective section of this report). This meant that people were not getting the full opportunity to make choices, be involved in activities of daily living or supported to communicate any concerns they may have.

We observed a staff member supporting someone to put some coffee granules in a mug they said, "Well done, that looks good." We saw another staff member saying, "Morning [person], what do you want for breakfast?" Although we saw that staff spoke to people with kindness and respect, we observed that during the inspection staff spent little time talking and engaging in activities with people. This meant that people were left to occupy themselves for long periods of time and staff did not have enough time to sit and talk to people or support someone to carry out an activity.

Staff were not always working with a person centred focus to support independence, in line with best practice. Staff told us that they knew people well and we observed staff completing tasks for people automatically. For example, we saw that staff prepared lunch and did not encourage people to be involved in preparing it. All people were given the same lunch and then the staff ate a different meal later, instead of all sharing a meal together where people are given choice. This demonstrated a task focussed culture, where staff carried out their daily tasks to meet the basic needs of people. People were not encouraged and supported to be actively involved in those tasks. One relative said, "I wonder if [person] does anything like helping to make food and drinks. [Person] helps when they come to my home and really enjoys it; it would be nice for them to do that at Seagulls."

Most people using the service were unable to fully verbally communicate due to their learning disability. Therefore, regular meetings with people were not being held, although the registered manager told us that the staff communicated with people to discuss potential trips out, special events or meal planning. There were no records of these conversations to demonstrate that people are involved in decisions about the home and things they may like to do. We saw no evidence of accessible communication tools being used, such as pictures or symbols to assist people to understand information and to make choices.

We saw staff respecting people's privacy and dignity by knocking on doors before entering rooms and speaking to people away from others when discussing private matters. We also observed staff members supporting people to go into the bathroom to take medication privately. For example, one person said to a staff member, "I need cream on my face." The staff member said, "I'll just get you your cream, let's go into the bathroom."

People's care records and personal information were not kept securely. During our visit we saw that a cupboard which contained care records and other information about people was in a communal area and was not locked. This meant that people's confidential information could be accessed by anyone and was not safe. We discussed this with the provider's representative for the home and following our inspection, a lock was placed on the cupboard.

The registered manager had carried out pre-admission assessments and had explored people's cultural and diversity needs. Although no-one at Seagulls had any specific cultural or religious needs, public holidays such as Christmas and Easter were celebrated with traditional food and activities.

Requires Improvement

Is the service responsive?

Our findings

Initial assessments of people's needs had been completed when people moved into the home. Care plans were then developed, which contained information about people's life history, and how they liked to be supported with personal care, and nutrition needs. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels. Copies of care plans were accessible to care staff should they need to refer to these. We found however, that care plans did not consistently contain all of the information required to enable staff to support people appropriately. For example information about people's health needs and guidance about any action staff should take were not in people's care plans and risk assessments had not always been carried out or were up to date. Further information about this can be found in the safe section of this report.

Although we were told that, the staff team knew the people who live at the service well, care plans should be written in a way that enable the person whose care plan it is to understand it as much as possible. We saw that care plans had not been developed with the person and had not been designed in a way that was accessible to the person. Care plans had not been developed in a way that would assist people to understand them or include the things they may wish to do. People were therefore not encouraged to express their own wishes and opinions regarding their care. Many of the people using the service had been there for a number of years and methods of communication had not been developed to ensure people were able to communicate their needs in a way that enabled them to be involved in choices about their care and treatment.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS. We discussed this with the registered manager and the provider's representative. They were unaware of this standard and that that they needed to develop information in a way people could understand. They agreed to look this and take action to make information accessible to the people at the service.

The registered manager told us that they have recently had the support of a professional employed by the provider to look at person centred practices and communication. However, the care and support people received did not reflect this. For example, people's care plans did not contain information that would enable a new staff member to understand how to support the person and how to communicate with them so they could make choices. We discussed this with one staff member who told us that they know the people at the service well. They said, "We just know what they like as we have known them for so long." However, a new member of staff would not have clear guidance about how to communicate with people.

Care plans should be reviewed regularly and involve the person and their family. We saw that reviews had not been carried out with people or their families. Therefore, people's care plans and risk assessments were not being updated to reflect changes. We discussed this with the registered manager who told us that reviews for all people would be arranged following our inspection. One family member told us, "We do not have meetings with the manager or staff about [person], the only review we have had recently was when the

social worker arranged one."

Some staff had received end of life training to assist them to support people at the end of their life and to make plans for any arrangements they would want. An audit carried out by the service in October 2017 and reviewed in December 2017 had identified that all people should have an end of life care plan. Peoples care plans did not contain this information and there was no evidence that discussions had been had with people or their families, if appropriate about end of life care.

Person centred care is considered best practice as it meets each person's individual needs and provides support that enables them to maintain or develop new skills where possible. We saw that staff were often doing things for people and making decisions for them. For example, at lunchtime the staff made the lunch and did not show people what different food they could have or support them to be involved in making it. This meant that staff were not actively looking for ways to offer choice or providing opportunities for further development. This showed us that there was a culture within the home of staff doing things for people, rather than seeking ways to enable people to be more independent.

The provider had not carried out effective audits or reviews of people's meaningful engagement in activities, how often people went out and their involvement in household tasks. This information could be used to increase understanding of people's needs and adapt their support accordingly. For example, one person who lived in the home had in the past worked in a café making hot drinks. This person was not able to independently make hot drinks in the home, as the kettle was too heavy for them to lift. We looked at the risk assessments for this person and found that restriction from the activity had been deemed as the most suitable way to prevent them from being hurt by lifting the kettle and potentially spilling boiling water. No consideration had been given to providing alternative equipment to enable this person to make hot drinks or a referral made to an occupational therapist to carry out an assessment or provide equipment. This risk adverse approach meant that this person was restricted from maintaining their independence. The provider had failed to properly assess this person's needs and make reasonable adaptations and adjustments that could enable their independence.

People who required individual person centred activities on a one to one basis with staff did not receive them as required. We looked at the records of one person who had a review in June 2017. It had been agreed with external professionals, that the actions to be taken to ensure the persons emotional wellbeing, included the person receiving 16 hours of one to one support on weekly basis. Daily records showed that the person had not received the one to one support as required. The service was not complying with the requirements related to the person's review. We found that very little had been recorded in respect of activities or social stimulation for this person. We asked for a record of the person's one to one support activities for the previous eight weeks; we found that the person had not regularly received the 16 hours of one to one support they required. The person's activities were not monitored by the provider for their suitability or for their provision. This person's assessed social needs were not being met.

The failure to ensure people received person centred care and support is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs within the home. However, people were going to some activities in the community. For example, in the last few months people had been to the theatre, on short break holidays and out to cafes for lunch. One person told us "I really like going to [activity], I go most weeks." We looked through care records to see what activities people did on a regular basis. We found that not all activities in the community happened regularly. We saw from information provided to us by the provider that plans for the registered manager to

develop more opportunities within the community for people, such as singing groups and specific men's groups, had not yet happened.

The home had a complaints procedure and this was available to people in an easy read format. However, not all the people who live at the home understood the easy read version due to their learning disabilities. The registered manager told us that the home had not received any complaints in the last year. We were told that if any complaints were received, they would be managed and recorded through the system that the provider had set up. We discussed the possibility of low level concerns being raised by people or their families that could be used to develop the service and learn from past experiences. The registered manager was not recording this information. This meant that the home was not making adjustments and changes in response to people's individual needs, concerns or complaints. We discussed this with the registered manager and advised using pictures or symbols to enable people to express any concerns or complaints they may have, in an informal way.

Requires Improvement

Is the service well-led?

Our findings

People and family members were happy with the service provided at by the home. They told us they felt confident to approach the staff or registered manager and felt they would be listened to.

There was a registered manager in place who was responsible for the day-to-day running of the service. However, the registered manager was also employed as the registered manager of another home, owned by the provider. This meant that their time was divided between the two homes and therefore impacted on their ability to ensure that the service was well run. The registered manager told us that they sometimes had to spend more time in one of the homes than the other, if there were issues that needed addressing. They said, "I have to prioritise where I am needed most in order to keep people safe."

The provider had not demonstrated good leadership in respect of the support provided to the registered manager. During the inspection, it was clear that on a number of occasions the registered manager was unable to complete all of the responsibilities associated with their role. We found that the registered manager had not received support from the provider that was commensurate to the registered manager's working hours. The registered manager worked 18.5 hours at this home as the registered manager; another senior member of staff complimented the manager cover by a further 7.5 hours a week. This combination did not cover a full time managerial post and we found that the senior member of staff was sometimes used to cover care staff tasks whilst undertaking their 'managerial' hours. A new interim group manager had started working with the service towards the end of 2017 however, they were not directly responsible for undertaking the responsibilities associated with the registered manager role. This combination of staffing issues at a senior level had contributed to the poor supervision of the service. This meant that the registered manager had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The provider had failed to provide sufficient time and structured support to enable the registered manager to undertake their role effectively and to a good standard.

Quality assurance processes were not robust. The provider had quality assurance processes to identify environmental risks, risks to people and to consider staff responsibilities and training. We saw that there had been two recent audits carried out on behalf of the provider in September 2017 and October 2017. However, these systems put in place to monitor quality and risk in the service, were not operated effectively. For example, the audits had not identified the lack of best interest decisions recorded in people's care plans or the restrictive practices around people's access to the kitchen. The quality assurance systems used were ineffective in assessing where
the service required improvement

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. Risk assessments were not always up to date, placing people at risk of not having all their needs met in a consistent and safe way. We also found that one person had the risk assessment for another person in their care file, this may have caused the person to receive inappropriate care.

The registered manager told us that the staff used pictures and symbols to support people to communicate their choices. However, we did not see examples of this in people's care plans or around the home. The registered manager told us that people were able to make their own choices. However, we saw evidence on the kitchen wall and in risk assessments for the environment and in people's individual care plans, which stated that people were restricted to what they could access in the kitchen. This meant that people were not able to access the kitchen to choose when they wanted food or drink. Robust risk assessments to consider how to safely support people to access all areas of their home had not been developed. Therefore, risks were being managed by unlawfully restricting people's movements in certain areas of the home.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. However, these were not being used effectively in order to identify any themes or trends, allowing timely investigations, potential learning and continual improvements in safety. For example, one family member told us that they had raised some concerns about certain aspects of their relative's care. Although they felt that this was acted upon eventually, they told us that it took a long time and there were no records to demonstrate actions that had been taken. We also saw that one person had been having some behaviour that challenges and this had not been analysed or evaluated.

People, their families and staff were not actively involved in developing the service. Reviews of care plans were carried out monthly by staff that checked through people's care files. However, we saw no evidence that this involved the person. Families told us that they had not been invited into a review for a long time. Following the inspection we were provided with evidence that one person had recently had a review. An external professional told us, "There were frequent meetings with myself, the person, their parents and the social worker." However, this was not recorded in the persons care plan. This meant that any actions or changes to the care plan as a result of the review had not been recorded. Quality assurance questionnaires had not been sent out and residents meetings were not being held. This meant that people and their families' views and opinions were not being captured or acted upon in order to develop and adapt the service.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the CQC must notify the CQC about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to all safeguarding incidents. The provider had failed to report incidents that had been referred to the local authority safeguarding team as statutory notifications to the CQC. For example, we saw an incident record that detailed one person having struck another person. This incident had been recorded and reported to the local safeguarding authority but not to the CQC. This meant that the CQC had been unable to monitor the concern and consider any follow up action that may have been required.

The failure to notify the Care Quality Commission about certain incidents, such as alleged abuse or serious injuries, to the Care Quality Commission (CQC) is a breach of the Registration Regulations 2009 – Notifications, Regulation 18.

There was a relaxed culture in the home and one staff member told us, "We all work together and help each other." The staff we spoke to all told us they felt able to raise concerns if they needed to and gave appropriate responses to safeguarding questions we asked them. The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff

were aware of the different external organisations they could contact if they felt their concerns would not be listened to.

Although people and staff appeared relaxed, we observed a risk adverse culture within the home where staff were doing things for the people who lived there, rather than supporting independence. The registered manager and provider had not recognised this culture or taken action to involve and aid people to be more involved in their own lives.

The provider's representative told us that recent links had been made with another provider whose service has been rated as outstanding. This was so that positive ways of working could be shared and training provided for the registered manager and staff. The registered manager told us that she had recently started the training available and had found it to be very beneficial. In addition, they told us that they had identified further training needs for the staff team and ways in which to develop a more person centred approach for the people at Seagulls. However, during the inspection we observed that the care and support people received did not always reflect current best practice guidance. For example, people's care plans did not contain information that would enable a new staff member to understand how to support the person and how to communicate with them so they could make choices. We discussed this with one staff member who told us that they know the people at Seagulls well. They said, "We just know what they like as we have known them for so long." This meant that the support people received and the choices offered were based on staff knowledge, and were not indicative of a continual reassessment and development approach that would promote increased independence for people.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in October 2015, was appropriately displayed at the home and there was a link to the CQC's rating on the provider's website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission about statutorily notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care and support. Care plans were not sufficiently person centred. People were not supported and involved in ensuring that care and support met their needs and that they were provided with regular meaningful and person centred activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act 2005 by recording decisions made in the best interests of people, who lack capacity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to prevent and control the risk of infection. Risk assessments were not reviewed and did not assess and mitigate risks

to people's health and safety.

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 The provider had failed to ensure that lawful authority was obtained before people were deprived of their liberty for the purpose of receiving care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to provide good governance to ensure the safety and quality of service provision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained staff to meet people's needs. Staff were not provided appropriate training, supervision and appraisals.