Hutchings & Hill Care Ltd

Seaview Haven

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Seaview Haven is a residential care home providing personal care for up to 44 people. At the time of the inspection there were 33 people living there. The home accommodates people across three different floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not always safe at the home as any risks to their health and wellbeing had not been assessed and planned for. People did not have care plans in place so they were at risk of not having their care and support needs met.

People were not protected from the risk of cross infection due to poor infection and control practices in the pandemic. People did not always receive their medicines in a safe way.

There were not always enough staff on duty and they did not have the necessary skills, training and supervision to support people effectively. Staff felt undervalued and demoralised with low morale.

Lessons were not always learned when things went wrong. There was poor oversight of the service and a lack of consistent managers in post. There was a lack of effective monitoring and systems in place to monitor the safety and quality of care were ineffective. Systems in place were not effective at sharing important information

People had access to healthcare professionals who told us they had good communication with the service.

Staff were recruited in a safe way. Relatives spoke positively about the care staff and how they supported their family members, particularly during the pandemic.

People were supported to have maximum choice and control of their lives in the least restrictive way possible and in their best interests; the policies and systems in the service were put in place.

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 good (published July 2019). The service had a targeted inspection (published October 2020) which was not rated. The service has deteriorated to inadequate. This is based on the findings at this inspection.

Why we inspected
We received concerns in relation to staffing levels, risks and safe care and treatment. As a result, we

undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

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

You can see what action we have asked the provider to take at the end of this full report.

Following the inspection the provider supplied an action plan with timescales for completion. They have committed to improving the service and working with health and social care professionals to do this. They have already began to make improvements throughout the service and have kept CQC updated on the progress.

Enforcement
We have identified four breaches in relation to: the safe care and treatment of people; safeguarding people from abuse; inadequate staffing levels and staff training; management oversight of the service, and a lack of monitoring quality and safety at this inspection.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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
We will continue to have updates on the provider's action plan to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Seaview Haven

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 following concerns being raised by the local authority. 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one assistant inspector.

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

The home did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first visit and announced on the second visit.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The local authority made us aware of a safeguarding referral they had and shared their concern with us. We received feedback from health and social care professionals who worked with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service. Many of the people were unable to tell us their experiences due to living with dementia. We received feedback from 10 relatives about their experiences of the service and spoke with one visiting community nurse.

We spoke with the provider, nominated individual, manager, deputy manager, care co-ordinator, five care staff, two housekeepers, the laundry person and a cook.

In addition to this, we received feedback from a further nine staff members who sent their responses by email.

We carried out a Short Observational Framework of Inspection (SOFI) to help us understand the experience of people who could not talk with us. We reviewed a range of records which included three staff recruitment, supervision and training files, two people's care records and medication records, daily care notes and falls records. A variety of records relating to the management of the service, including audits, quality monitoring and policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At the last rated inspection this key question was rated as good. At this inspection this key question has deteriorated 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 always protected from abuse or neglect.
- There was no robust system in place to ensure staff received training to help them identify different types of abuse. The training matrix showed 12 out of 24 care staff and six out of 10 non care staff had undertaken safeguarding training. Not all staff who had undertaken training applied this to their practice. The cook had no training and they worked in isolation in the kitchen.
- Some staff said they knew how to recognise and report signs of abuse. Other staff were not so clear. One staff member said, "I'm unsure about safeguarding and restraint" whilst another said, "I am fully aware of what action to take."
- Staff told us they did not feel able to report all concerns when they happened due to fear of being held to blame. One staff member said, "… I do not have confidence some of the managers would listen to me."
- The manager told us they thought safeguarding incidents were not always recorded or reported. They felt the records were not up to date.
- From one person's daily record, an incident had occurred which had affected both the person and a second person. The deputy manager checked the staff handover sheet from the night staff which contained no information of concern. Therefore this information had not been passed over and the management team were unaware it had happened. This meant immediate action had not been taken to ensure all possible action had been taken to protect people.

Due to poor safeguarding systems, processes and practices at the service, people were placed at risk of harm. This is 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.

Following the inspection, we reported three safeguarding incidents to the local authority safeguarding team. This was because we were not confident these had been recognised by the provider.

Preventing and controlling infection

During a targeted inspection in September 2020 we were assured infection prevention and control measures were in place at the time.

- At this inspection we found widespread failings throughout the service with regards to infection prevention and control practices which meant people, staff and visitors were not fully protected from infection control risks.
- Following a visit from the Food Standards Agency in 2020, the safety rating for the kitchen had dropped from five stars to three stars. This meant improvements were needed. The cook told us these had all been completed now, including a new ceiling, deep clean and decorating.

●Due to the continuing of the COVID-19 pandemic, extra measures had not been embedded in the service to keep people safe. The service was not following the latest guidance from the Department of Health to ensure these were adhered to.

●There was no detailed admission criteria for people entering the service who may have COVID-19. This meant people might move into the service and be a source of infection for other people already living there.

●The COVID-19 Contingency Plan was dated 17 September 2020. This did not cover specific practical steps for staff to take should a person test COVID-19 positive, for example cohorting people and staff and cleaning procedures.

●There was no COVID-19/pandemic specific cleaning schedule. The housekeeper told us they cleaned in the same way as before the pandemic. High usage touch points, such as toilets, handrails and door handles were cleaned once a day. Equipment, such as hoists and beds, were not included on their cleaning schedule, despite communal mobility equipment being in use.

●There was an unfinished Infection Control Audit dated 31 January 2021 (following our first inspection visit) which stated, 'effective arrangements for the appropriate cleaning of equipment, hoists, beds, commodes incorporating appropriate cleaning, disinfection and decontamination policies' was 'to be implemented'. However, the pandemic had started in March 2020 and improved cleaning practices needed to have been in place from this date.

●Slings for hoists were not used for individual people but communally. Slings were stored on top of each other which meant they were subject to cross infection. There was no cleaning schedule in place for the slings.

●There was nowhere suitable, in or close to, people's bedrooms for staff to don and doff their clean and used PPE. Staff were also unable to wash/sanitise their hands following delivery of personal care. Staff had to walk down a long corridor to the nearest bathroom to do this.

●Staff did not use PPE appropriately. For example, several staff continued to wear the same PPE when supporting several different people. One care worker went from person to person, hugging and touching them, with no sanitising in between.

●Staff used a 'do not disturb' cloth tabard when giving out people's medicines. This was not cleaned in between medicine rounds, but put back for the next staff member to wear. No other PPE was used.

●Staff had been instructed to wear cloth tabards over their uniforms if not delivering personal care. One staff member was seen pushing a food trolley into the kitchen wearing one. Another staff member carried dirty laundry from the person's bedrooms to the laundry room. These tabards were not discarded to be washed after they had been used. The use of cloth tabards and lack of washing increased the risk of cross infection.

●There were minimal social distancing measures in place. Staff were not keeping apart, where possible. For example, staff would go between floors to help, but PPE was not changed between floors. As staff were based on separate floors, they were not working separately where possible to reduce the risk of spreading infection between units (staff cohorting).

●In the large communal lounge and dining room on the ground floor, the chairs and tables had not been spaced out, so people were sitting directly next to and opposite one another. There was no evidence of staggered mealtimes or serving people in different areas of the home to ensure social distancing could be followed. The communal lounge area was larger, but chairs were placed together in close vicinity of each other and staff did not monitor people's social distancing.

●From observations, staff training records and discussions with staff, not all staff had infection control and training knowledge. The staff matrix showed that out of 23 care staff, only 12 had undertaken training. No specific training on COVID-19 had taken place. For those staff who had undertaken training, their knowledge of the correct procedures to take were unclear. For example, one staff member's infection control training took place in 2019 and had not been updated since the pandemic.

●Systems for visitors entering the home were not robust. A skin thermometer was used which was not

cleaned in between uses. No checklist was undertaken to check visitors did not have signs or symptoms of COVID-19 before they entered the home. However, feedback from relatives told us measures had been in place when they had visited the home last year, but we saw this was no longer the case.

Due to the lack of robust infection prevention and control measures in place at the service, people were placed at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Immediate lateral flow testing (LFT) had not yet begun in the home for visitors but supplies had been delivered to carry this out.
●The provider ensured staff and people who lived at the home undertook the required polymerase chain reaction (PCR) testing to ensure they were COVID-19 free.

Assessing risk, safety monitoring and management
●Risks were not accurately assessed and planned for. We found no risk assessments or care plans were being used to manage people's current individual needs. This was widespread throughout the service. The management team confirmed these records were not in place.
●We were shown separate summaries of people's individual needs. However, the manager told us these were out of date and had not been in use since September 2020.
●One person presented a risk to both themselves and other people with behaviour which may be challenging. We found on one occasion in the daily records where such an incident had recently occurred. Staff had not reported this to the management team who were unaware of the incident. This person did not have a care plan or risk assessment in place and consequently there was no guidance for staff in how to manage these incidents in the safest way. There were also no triggers to identify why these episodes may occur.
●A second person was at risk of choking. Whilst we were told a referral to the Speech and Language Therapist (SALT) team had been made, there were no records to support this referral. Care records contained no information as to how this person should be supported to eat their food. The cook and care staff confirmed this person did receive a pureed (soft) diet at each mealtime but were unaware why.
●Some people living at the home had bed rails in place to prevent them falling out of bed. The management team were unaware of which people had bedrails and they were not checked regularly to ensure they were being used correctly.
●Some people slept on air mattresses to minimise the risk of skin damage. There were no checks in place to ensure this equipment was working correctly. No records were kept ensuring these specialist mattresses were at the correct setting in line with the person's latest weight. This meant people may be at risk through lack of equipment checks.
●Staff told us they did not read or use care plans. One care worker said there used to be care plans, but they did not know where they had gone. Staff relied on the daily staff handover. However, these handover meetings had only just recommenced after being stopped by a previous manager.
●New staff were recruited and would rely on verbal information to keep people safe. One newly employed care worker was asked to read care records relating to two different people to get to know them. However, these records did not contain a care plan or risk assessment for them to refer to.

Due to the lack of risk assessments and safety monitoring systems in place, put people at risk of harm. This is a breach of regulation 12 (Safe treatment and care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●Medicines were not always managed safely which put people at risk.
●The deputy manager said there were only four care staff who could give out people's medicines, as well as the nominated individual and the new manager. This meant the staff rota had had to be changed frequently and staff had to do increased hours to enable medicine rounds to be completed by suitably trained staff.
●On the day of our inspection, the medicine round took four hours to complete as the care worker had recently come off night shifts and was 'acclimatising to day shifts'. This meant there was less staff to support people during the shift.
●People who had 'as and when required' (PRN) medicines did not always have protocols in place to help staff identify when they needed their medicines. Two medication administration records (MAR) stated that there were no PRN. One said, 'I am not prescribed any medication required as and when (PRN)'. However, each person was on an 'as required' medication if they became upset, agitated or presented behaviours that needed positive staff support. These medicines had been given on various occasions. There were no instructions for staff about how to determine when to administer these medications or what actions to take first. The care worker said, "We know when (person's name) needs it. They get aggressive."
●There was a medication audit form that was last completed 8 August 2020. Some areas were non-compliant and had actions for the management team to take. For example, to meet with the pharmacy, to check medicine administration charts daily for gaps in recording and to follow up on discrepancies/investigate why a medicine was not given. There had been no action taken and the management team were unaware of the actions required.
●The deputy manager told us the nominated individual had organised for an independent person to undertake a medication audit on 30 January 2021 (after our first inspection visit). There were areas of non-compliance identified, but no actions to be taken to reduce any risk had been taken or recorded. For example, in relation to gaps in medication administration and whether tablet stock tallied with the medicine administration chart, 'unable to check as not recorded all amounts.
●Medicines which required stricter control had not been checked weekly by two members of staff when signing them in to stock. The deputy manager said this was because there was not enough medicine trained staff on duty to do this.
●Room temperatures where medicines were stored had not been carried out and the medication room was not clean and untidy and dirty. Stock was waiting to be processed.
●Medicine trollies were not included in the enhanced cleaning schedule during the pandemic. This meant there was a risk of cross infection.

Due to poor medicine management at the service, people were put at risk of harm from cross infection and not receiving their medicines as prescribed. This is a breach of regulation 12 (Safe treatment and care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
●The inspection history for the service shows there had not been learning from previous issues, for example in relation to skin integrity. There had been incidents of people having unnecessary pressure sores last year. At this inspection there had been a similar incident reported with one person having skin damage which could have been prevented. At our targeted inspection in September 2020 we made a recommendation to the service that they followed the latest guidance in relation to managing pressure sores. This meant this guidance had not been embedded into staff practice.
●In the previous two years, the local authority quality assurance and improvement team had supported the service on several occasions. This was to improve the management of the service and put systems in place to monitor and improve the quality of service. The lack of adequate monitoring of the service by the provider meant these systems were not being used effectively.

Due to the lack of monitoring and learning from incidents at the service, people were put at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we contacted health and social care professionals about the concerns we had found in relation to people's safe care and treatment.

The service sent us an action plan with timescales as to how they would address the shortfalls found.

The local authority planned to carry out a review of care for one person following a safeguarding alert we made.
Training and support from the local hospital and care homes education team was organised to help with the infection prevention and control concerns.

Staffing
●People's dependency levels were not monitored to ensure their care and support needs were always met with the correct numbers of staff on duty.
●There were not always enough staff on duty at the home and staff were not always effectively deployed. For example, the medicine rounds took staff excessive time over three floors. There was no activity co-ordinator, so staff were expected to provide engagement and activities for people. This was not happening.
●Feedback from all staff, without exception, confirmed a lack of enough numbers of staff on duty. Care workers said staffing was a major concern for them, particularly in the last few months. They found their job difficult with the change of care staff and management. One staff member said, "We are too often understaffed and therefore it makes it quite a stressful place to work".
●Staff generally worked 12-hour shifts. Staff said they regularly missed or had delayed breaks and gave numerous examples of when this occurred due to lack of staff able to cover them. One area of concern seemed to be the third floor where staff worked alone. One care worker told us they were told on one occasion to take their break in a spare bedroom and not leave the floor. This would have left people unsupervised and at risk.
●The night duty was also a problem to cover with staff telling us these shifts were difficult to cover. Some staff told us they were moved from days to nights and this had caused them problems both in their wellbeing and in their work. Care worker comments included, "… we never get a break … the senior was doing medication until 11pm so just two people to put everyone to bed … lots of people were often left unsupervised in the lounge. You do laundry and the veg and towels for the next day – they just kept on piling up the tasks" and "Every decent staff I worked with slowly left and then agency started to come in at night … then they started dragging people off the day shift and then put them on at night and so they started leaving".
●There was the potential for mistakes to be made because of the number of hours some staff worked each week. One senior member of staff had worked over 60 hours one week and was extremely tired. Staff said they felt under pressure to work extra hours and that they were expected to do it.
●Staff reported they were unable to give quality time to the people they supported due to the staffing levels and the complexity of people's needs. One staff member said, "The needs of residents has changed, and we do seem to have quite a few that needs constant monitoring due to them being falls risks and we just don't seem to have the staff to watch them".
●Some people walked purposefully and lived with dementia. A location sheet was used for one person to ensure staff knew where they were. We saw this sheet on two occasions in different places to where the person was. On one occasion, the sheet said 'in their bedroom' when in fact they were in the communal lounge. This meant staff were unaware of where this person was and the monitoring was ineffective.

●Staff turnover was high. Before Christmas last year, 11 staff all left within a short period of time which left the service extremely short staffed. This was covered by permanent staff and agency. However, management and staff told us not all shifts were able to be covered. We were told the turnover of staff put additional pressure on existing staff because of their need to orientate and support new staff.
●Staff highlighted the third floor as a problem with staffing. On this floor there were three people who needed support from two members of staff but there was only one staff on duty on this floor. A staff member from another floor had to help the staff when needed. This also meant staff were not cohorting in line with infection control and prevention guidance.

Due to the lack of sufficient numbers of suitable staff on each shift at the service, people were put at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff were recruited safely. Checks were made on staff members suitability, such as employment history, references and criminal convictions.
●The cook worked on their own and had raised concerns about the lack of support in the kitchen due to not being able to complete all their tasks. The management team had listened to this and had recently employed kitchen assistants to support them in their role.

Following the inspection, the service confirmed there were four new members of care staff awaiting their safety checks before employment. There were a further four vacancies the service was actively recruiting into, both regionally and nationally.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not effectively trained or supervised to ensure people were always well supported.
- New staff in post did not have an effective induction. They were given a day's orientation and then shadowed a member of staff. Their care practice was not monitored, and competency checks not carried out. Therefore, management were unsure if they were supporting people correctly.
- New staff were unsupported in their job roles and did not have access to an induction programme such as the Care Certificate (recognised as best practice induction training).
- Shifts were managed and worked by several staff who were not fully trained in key areas of care. Where they had received training, staff did not always apply this to their practice. Records showed gaps in their training included Mental Capacity Act awareness, safeguarding and behaviour which challenges and needs positive staff support.
- Staff did not have regular supervision. Some staff reported not having supervision for over a year. This meant any deficits in their care practice might not have been highlighted and addressed. Two staff said, "… feel like supervision has been lacking, when I started I was told it would be regular, but in the 18 months I've only had supervision or a discussion about how I'm working and feeling twice" and "Supervisions/training have been quite poor".
- All staff were very emotive about their jobs and spoke of unhappiness and stress at work. One staff member said, "I was just cracking, I had to go and see my GP and I feel like I have failed the people, but I could not go on". Other staff said, "Staff morale at the moment seems to be at an all-time low and "Very stressed at the moment due to staffing levels."
- Staff told us there was no system to ensure all staff were offered an interview on their return to ensure they were fit for work. Some staff said they were frustrated when staff repeatedly rang in sick as they felt this was not addressed effectively and put undue pressure on remaining staff.
- Exit interviews for staff that left the service did not routinely take place, so the service was not collecting feedback to understand why staff left. One recently left staff member said, "I left my job feeling undervalued and demoralised without the opportunity of an Exit Interview". Another person said, "I witnessed staff being upset and struggling to cope".
- Staff were promoted from within the service but expressed concern about the quality of their induction and training to prepare them for their new role. For example, one senior member of staff felt very unsupported in their promotion, which led them to feeling stressed in the workplace.

Due to the lack of skills, training and supervision of staff at the service, people were put at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

●Despite the low morale, staff said they remained in post because of their love for their job and their relationship with other staff members and people living at the home. Comments included, "I love working here … I am here because I genuinely like caring", "It's not that staff are bad, it's just we feel unsupported" and "We are all trying very hard at Seaview".
●Feedback from relatives was positive about staff and included comments such as "Every time I speak to them (staff) they are lovely and helpful", "The staff have been fantastic" and "The staff always speak very nicely to (relative)".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Handovers were not always effective at ensuring important information was passed on. A record of a recent handover sheet showed important information was missing and not passed over. A care worker told us of the difficulties they had when returning to work after their days off when they had not been updated on people's changing needs.
●There had been no analysis undertaken to look at trends or patterns of falls. The manager said not all falls were being reported. Because of this it made it difficult for the manager to learn lessons and put improvements in place if they were not reported and documented. One relative commented their family member had sustained a fall recently. This had not been recorded in fall records. The manager had taken steps to improve this practice during the inspection.
●People had access to other health professionals when appropriate. The service worked closely with the local community nursing teams who reported good communication and partnership working together. This had a positive impact on the people living at Seaview Haven and improved outcomes for people with health needs.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

●On our first day of inspection, there was poor oversight of DoLS applications so it was not fully known who had an application submitted, what the outcome was of an application (if there was an outcome) or whether there were any conditions if an application had been granted.
●Some people were being restricted in their movements and this had not always been considered or included in DoLS applications. For example, those people with bedrails or pressure mats in place (which raise an alarm when the person moves).
●On our second day, action had been taken and completed. An audit of those people who required a DoLS

submission to the authorising authority had been made. Urgent applications had been made where necessary and these were being followed up by standards applications.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they enjoyed the food and had a choice. We observed choices available for people and those who needed support with eating were given this.
- The menu plans showed food was varied and nutritious. Food was home cooked and looked very appealing.
- There were two new cooks in post. Staff told us of the improved menus and choice of food for people. They described it as "brilliant" and "they're great cooks and a massive improvement".
- People were supported to eat their food when needed. However, there were no details in a care plan to show if staff were doing this in the right way. For example, one staff member followed a person round pushing a chair whilst supporting them to eat. Another staff member was standing over one person whilst assisting them with no conversation taking place. This was discussed with the manager at the inspection.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

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

- There were widespread and significant shortfalls in the way the service was led. The previous registered manager and nominated individual (responsible for supervising the management of the service) resigned and left the service in October/November 2020.
- Since then, a further two managers have started employment and left within a few weeks of them starting work.
- The service has a history of high manager turnover and has had a succession of managers since it was first registered in 2017. This had led to inconsistent leadership and changes in management styles which had affected staff working at the service.
- A new nominated individual (NI) was appointed in October 2020 when the previous one left the service. This NI also handed their notice in during the inspection and left shortly after the inspection.
- No exit interviews had been carried out by the provider for these key roles, so their reasons for leaving were unknown.
- In November 2020 the service employed a deputy manager. The deputy took over as manager of the service a day before our first inspection visit. The manager is supported by a care co-ordinator and a new in post deputy manager. A second deputy manager is currently on maternity leave.
- The service had not been well managed and was unsafe due to the five breaches of regulation linked to good governance, medicines, risk, infection control, staffing and safeguarding.
- The provider had not recognised the quality of the service had significantly deteriorated. They did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively. They had therefore put people at risk of unsafe care.
- The provider had not identified staff were not suitably trained and not employed in sufficient numbers to keep people safe.
- The provider had not identified medicine audits were not carried out and that medicine may be stored at incorrect temperatures.
- The provider failed to ensure infection control was well managed in the home to ensure people were not at risk of cross infection.
- The provider had failed to ensure all people who lived at the service had an up to date and complete risk assessment and care plan to fully meet their needs.
- There was a lack of consistent oversight and leadership of the whole service and a continual improvement

of good practice. They had seen several managers start and leave the service and therefore no continuity of management. Some issues had not been addressed and left to escalate. For example, staff numbers, training and supervision.

Due to the lack of governance and oversight of the service, people were placed 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.

●The new manager in post had recognised this and was hoping to provide that continuity. Along with the service co-ordinator, they were motivated and enthusiastic about improving the service. They were in the process of defining their roles, so they knew what each other's responsibilities were.
●There had been some disharmony and effective working within the management team. However, these had been identified and were being resolved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Since the beginning of the COVID-19 pandemic, the provider had not ensured people visiting, working or living at the home were updated, asked for their views or reassured about the running of the service. One relative said, "I used to visit two or three times a week … since March I think I have seen them 4 times. I have no idea how she is; I have not had any newsletters or updates. They used to have a Facebook page but that has completely stopped so I cannot see any pictures." Another said, "…no-one ever contacts me (about updates)."
●A further three relatives told us they had not visited the home since their family member went to live there. They said, "We cannot get access so have no idea what their rooms are like. We have been unable to communicate properly", I do not feel particularly informed … it is not how I expected it to be" and "I have never seen the place, I had to choose it from the internet."
●One relative told us management had informed them their family member had to move rooms with a significant increase in fees. No real reason was given and the relative felt unable to question this due to not being able to visit. They have not seen pictures of the room so are unaware of why the increase occurred.
●Without good reason or assessment of risk, the nominated individual had stopped all visitors coming into the home to visit. The manager and co-ordinator did not know why this decision had been made. Relatives informed us they had visited previously either in the 'pod' in the car park or through a window. They had enjoyed this very much.
●Resident and relative meetings had not taken place and views not actively sought. Feedback from relatives showed a clear concern they had that no activities took place in the home. Some said their relatives were concerned there was no stimulation or any taking part in hobbies/interests. One relative said, "… they do just seem to watch tv all day". We discussed this with management and staff who all said activities no longer took place and there was no activities organiser in post. Staff said they do not have time to engage people in activities. When we visited on both days, the television was on in the lounge for the duration of the visits with nobody actually watching it.
●Staff told us they did not feel involved in the running of the service and that their opinions did not matter. Some staff spoke of difficulties working with certain members of the management team, whilst other staff spoke positively about them.
● Staff did not have regular supervisions or staff meetings. This meant there was no forum for staff to discuss any concerns before they escalated. They did not have the opportunity to address any issues relating to their wellbeing, training or morale.

The lack of consultation with staff, people and families is a breach of regulation 17 (Good governance) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Staff did not feel valued by the provider. They felt their commitment was not recognised and had no appreciation or recognition for their hard work during the pandemic. Staff talked about their experiences during the pandemic and the pressure to support each other during the crisis. One ex-staff member told us they had been instructed to work four out of the five key dates at Christmas and New Year. However, their rota meant they had to work for nine days without a break from Christmas Eve onwards. When they questioned this with management, they were told the rota would not be changed and they had to work. This left them feeling "undervalued and demoralised" and they left their job.

●For some staff the COVID-19 had impacted on their emotional well-being. One care worker said, "… staff morale was at an all-time low" and another said, "Staff morale at the moment seems to be at an all-time low, we all try and bolster each other up and we all seem to get on well with each other and are all supportive."

●The provider's management style had been an issue for some of the previous managers, with them not feeling they were able to manage the home safely and appropriately. This did not demonstrate a positive culture which was open and inclusive.

●The new manager started in post on 1 February 2021. They had already began addressing poor infection control practice, staff training and risk management. One person's care record and risk assessment had been re-assessed.

●Staff feedback about the manager's approach to introducing change in the way the home was run and care provided was mixed. Some staff said the changes were made for the better and spoke of their liking for the manager. Others felt they were harsh in the standards they expected of staff. One staff member said, "I find the young people who work with them (manager) do not like it because they tell them as it is, and they do not let them get away with things."

Working in partnership with others

●Since the last inspection, partnership working between the service and the community health care professionals had improved. Professionals spoke of the improved lines of communication which had improved outcomes for people living at the home.

●Following the inspection, the provider sent us an action plan to address immediate risks. This showed they took the concerns raised seriously and took quick action to start improving the quality of the service and the safety of people living there.

●The local authority safeguarding team and quality and assurance improvement team was supporting the service due to concerns raised and the provider was very positive to have this support.

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

●Both the provider and manager were open and transparent with us during the inspection. They were committed to improving the service and had already taken steps to do this. This gave us confidence in their actions.

●The previous inspection rating was being displayed in the home and on the provider's website, as required.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a lack of systems in place to keep people safe Regulation 13 (1) (2) (3)

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 There was a lack of people's risk assessments and plans of care in place. There was a lack of safe medicine management systems in place There was a lack of risk assessments and safety monitoring systems in place There was a lack of robust infection prevention and control measures in place Regulation 12 (1) (2) a,b,c,g,h

The enforcement action we took:

We imposed a positive condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of governance and oversight in place There was a lack of consultation with people, families and staff involvement in the running of the service Not all records relating to the running of the service were in place

The enforcement action we took:

We imposed a positive condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of suitably trained and

supervised staff on each shift

There was a lack of sufficient numbers of suitable staff on each shift

Regulation 18 (1) (2) a

The enforcement action we took:

We imposed a positive condition on the provider's registration.