Waterfall House Ltd

# Seaforth Lodge

## Inspection report

Carlton Road
New Southgate
London
N11 3EX

Tel: 02083612634

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection took place on 7 February 2017 and was unannounced. We last inspected this home on 10 February 2015 where no concerns were identified and it was given an overall rating of Good.

Seaforth Lodge is registered to provide accommodation for up to 24 people who require nursing or personal care. The people living in the home are predominantly older people with needs around dementia. At the time of inspection there were 18 people living there.

Seaforth Lodge requires a registered manager to be in post as part of its registration requirements from the Care Quality Commission. There was a registered manager in post at the time of the inspection and they had been registered since July 2016. 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.

Relatives and people told us staff were caring but at times there were not enough staff. People's privacy and dignity was not always maintained and there were not always enough staff to provide person centred care to people.

Staff we spoke with understood what abuse was and how to report it if they had any concerns, although they had not attended safeguarding training. We saw that safeguarding concerns were not always reported to the local authority to be investigated.

Staff recruitment procedures were in place and the provider had a policy to ensure they were employing appropriate people.

We found the recording and administration of medicines was carried out by staff that had their competency checked regularly and there were no gaps in the daily administration of medicines. On the day of inspection medicines were administered two hours late which went against the advised time they should have been taken.

Nutritional needs were not being met and we had to intervene to point this out. There were no fresh fruit or vegetables available and the food was not nutritionally balanced. We saw that advice from dieticians was not being followed for people who were at risk of losing weight and malnutrition.

There was a complaints procedure in place and available to people and visitors. People felt comfortable complaining and said they could talk to staff and the registered manager.
The principles of the Mental Capacity Act 20015 were not being adhered to in care and consent documents. There was a lack of understanding in the service around consent and best interests decisions.

Care documents and care were not person centred. People were not always involved in the planning of their care.

There was a lack of oversight from the provider and quality checks did not pick up on gaps in risk assessments, consent documents and where needs were not being met.

We found risk assessments were inconsistent in places and were not clear on how risks could be minimised. People were being put at risk due to the disrepair of the building and equipment.

We found overall that people were at risk of receiving unsafe, ineffective care. We found breaches of nine of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider and will report further on this when it is completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

There were not enough staff to meet people's needs. This meant people were placed at avoidable risk of harm.

Safeguarding systems were not robust. Staff were not trained in safeguarding and concerns of abuse were not always reported.

Appropriate equipment was not in place or faulty on the day of inspection. Wheelchairs were broken and there was no standing hoist.

Medicine administration records had no gaps. Medicines administration was up to two hours after the prescribers recommended time.

### Is the service effective?

**Inadequate**

The service was not effective. The principles of the Mental Capacity Act 20015 were not being adhered to in care and consent documents. There was a lack of understanding in the service around consent and best interests decisions.

There were gaps in basic training such as safeguarding, dementia awareness, and moving and handling.

Supervision was taking place regularly and being recorded.

Nutritional needs were not being met. Some people were not being given supplements in their diet when a health care professional had recommended they needed them.

### Is the service caring?

**Requires Improvement**

The service was not always caring. Staff tried to make people comfortable but were rushed. People and relatives told us staff were caring.

People's privacy was not always respected. Calls to relatives were on loudspeaker in communal areas.

Language and names of documents used by the registered manager were not respectful of people.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive. Care documents and care were not person centred. People were not always involved in the planning of their care.

Activities were limited and we saw little stimulation for people on the day of inspection.

People and relatives felt comfortable to complain.

## Is the service well-led?

**Inadequate**

The service was not well-led. The registered manager was aware of some improvements that needed making but quality checks did not pick up gaps in records.

The provider did not provide equipment and specific food as recommended by health and social care professionals.

The registered manager spent time writing care documents rather than having oversight of the service, due in part to insufficient staffing levels.

Staff felt stressed and rushed and not listened to.

# Seaforth Lodge

**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.

The inspection took place on 7 February 2017 and was unannounced.

The inspection team was made up of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we reviewed previous inspection reports and information on notifications we had received from the service.

During the inspection we spoke with four people and observed interactions between care staff and people in communal areas. We spoke with seven family members. We interviewed seven care staff members, and the registered manager. We tracked the care records of nine people. We looked at personnel files for three staff members, and daily notes, training records, complaints, safeguarding records and quality control documents.

We also contacted social workers and health care professionals and had feedback from the local authority.

Inadequate

# Is the service safe?

## Our findings

We asked people if they felt safe in the home, they said "yes" and "I feel comfortable". A relative said "yes- it's the only place they know now" and another said "it's safe." Staff we spoke with felt people were safe but they were only having their immediate needs met.

We looked at the safeguarding systems in place to keep people safe. Staff had a basic understanding of different kinds of abuse and said they would go to their manager with any concerns. The staff training matrix 2015/2016 showed that safeguarding training was to be completed every two years. This document noted this was in date for only four staff out of 17, and four staff had never attended safeguarding training. We asked the registered manager why there were so many people that had not attended this training and we were told that it was going to be booked but had not so far. The provider and registered manager had not taken reasonable steps to ensure care staff had been equipped to manage suspected abuse or how to safeguard people from harm.

We observed a medicine being offered to one person in the communal lounge. The person said they did not want to take it. Two care staff were standing over this person during this exchange. One care staff member held the person's hand down when they tried to lift their hand and said "If you don't take it I will call your son." We told the registered manager of this and asked them to take appropriate action and make sure the person was ok and the issue was investigated. After the inspection we were sent details of an internal investigation after reminding the registered manager of this incident. Despite us feeding back directly that we had witnessed a concerning interaction, a referral was not made to the local safeguarding authority. Safeguarding processes were not being followed to ensure that allegations of potential abuse were reported to the local safeguarding authority. We saw unnecessary restraint had been used and a person's rights not respected that resulted in demeaning treatment.

The above evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed care staff were rushing and asked them to carry on with providing breakfast rather than talk to us. We said we thought people may be hungry and thirsty if they had not yet had breakfast, and we would wait for the registered manager to arrive. We saw throughout the day that staff were task focussed and constantly rushed. There were two care staff and one senior care staff and the registered manager on the day of our inspection. We checked the rota and this matched the number of staff that were on shift.

We asked people and their relatives if they thought there were enough care staff in the home. One relative said "They are a bit rushed off their feet at times", another told us they always saw three staff members in the lounge and felt this was enough. People that we spoke with said "Yes", "there are two or three on all night", and "I have no idea."

Care staff we spoke with said people were having their basic needs met but there were not enough staff. One care staff member said "We are very short of staff, no time for one to one. We are so busy" and another said

"The main thing is they need more care staff and it is not fair on us or the residents. Sometimes we don't have a break. We can't give as good care or attention." Staff said they had told the registered manager there were not enough of them and asked for more staff. We observed care and saw where the lack of staffing was having an impact on people and the quality of care they were getting. For example, one person was being supported to eat. The care staff supporting them was called away five times throughout the meal to meet the needs of other people. The food was cold by the time they returned to support the person eating and they did not want to continue with their meal.

We asked the registered manager if they thought there were sufficient number of care staff and how they calculated staffing levels. The registered manager said "There is not enough, we are too busy" and said they were included in the calculation of care staff. They showed us an individual capability risk assessment which outlined that three people were mobile and every other person required support of one or two staff members to mobilise. This document showed that eight people required the support of two care staff with personal care and ten required the support of one staff member. There were three care staff on shift to provide personal care including washing or bathing, getting dressed, and administering medicines and providing breakfast with some people requiring assistance to eat. This would mean some people would wait a long time before receiving personal care.

We saw in the day one person needing the support of all three care staff on shift to be hoisted with the full body hoist in the lounge. This left no other care staff to support other people at the time of hoisting. Throughout the day care staff were rushing and did not have time to sit or have conversations with people but instead focussed on tasks. There were not sufficient numbers of staff on shift.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medicines records and observed medicines being administered. There were no gaps in the Medicines Administration Records (MAR) and medicines were being recorded as being administered as they were given. The registered manager told us that only senior carers who were trained in administering could administer medicines. The senior carer administered the medicines on the day of inspection. Care staff who administered medicines had their competency assessed twice a year. Medicines were stored in a locked medicines trolley. We looked at covert administration of medicines, where people were assessed as needing to be administered medicines in a disguised format. For one person being given a medicine covertly, there were no supporting documents to show why the person needed to be given medicines covertly. There was no evidence of it being reviewed every six months, as their needs assessment stated it should be and no instruction to care staff as to how the medicine should be disguised. The needs assessment stated "Manager to seek advice for crushing and opening capsules from the pharmacist." There was nothing in place to show this had been followed up and that advice had been sought from a pharmacist.

We arrived at the inspection at 9am, and saw medicines had not yet been administered and people had not had breakfast. The medicines round started at 09:50am and for people who had medicines prescribed to be taken at 8am or 9am this time was not being adhered to. We saw from MAR the majority of people needed medicines to be administered at 8am according to their MAR charts and they did not receive them until after 9:50am. Some people received their medicines two hours late which was against the advice of the prescribing medical practitioner recorded in the MAR chart.

Risk assessments were completed by the registered manager who said care staff did not have time to complete them as they were so busy. They were in place for each person in the home and reviewed every 6 months. We looked at care records and saw in some places risk assessments were comprehensive in their

structure but the content was inconsistent and vague in places. We saw that some of these records had general language in them, such as "monitor blood sugar levels" for people with diabetes without saying what a safe level was or how often and in what way they needed to be monitored. For one person with diabetes the description of how their physical and mental needs were going to be met was "provide with a lot of reassurances and tender loving care." There was no description of what safe care looked like and how it should be provided for this person.

Recording of important risk information was inconsistent across documents for several people. For one person with diabetes their risk assessment described them as having type two diabetes which was medicine controlled. Another document which listed people with diabetes stated this person had diet controlled diabetes so it was not clear what type of diabetes they had. For another person the nutritional screening and risk assessment dated stated they had a normal diet with food cut up. Advice from the speech and language therapy team noted they needed a soft diet cut up. The list of people in the registered manager's daily file had this person recorded as needing a pureed diet with fluid thickener. This person was at risk of choking and it was unclear what their dietary needs were to minimise the risk of choking.

Another person had been assessed on coming into the service as being at risk of urinary tract infections; this was not mentioned in either the risk or needs assessment. The needs assessment for this person stated "Is doubly incontinent and needs to be toileted every 2-3 hours." The toileting regime recorded when people had been supported with their continence needs. For this person they were recorded as being supported with continence needs at 8am on 3 February 2017, at 8am, 1pm and 5pm on 4 February 2017, and 8am and 7pm on 6 February 2017. This person was being put at risk of developing urinary tract infections due to not having their identified continence needs met. There was not a management plan in place to assess, review or minimise the risk this person faced and they were being placed at risk of avoidable harm. We fed back the gaps we found in risk assessments and the registered manager said they would look at how risk assessments were done in the home.

There was not a standing hoist used in the home. The registered manager said they needed a standing hoist and had requested one but this had not been provided by the provider. The individual capability assessment noted "People who can benefit with standing hoist: 6." Six people had been assessed as needing the standing hoist to prevent falls and help them to feel safe and the appropriate equipment to minimise the risk of falls had not been provided.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at other equipment in the home, we saw that there were three wheelchairs available, 12 people needed a wheelchair to move a short or long distance. We noted that all three wheelchairs were soiled and damaged and were unsafe to use. We asked the registered manager what they had done to remedy the unsafe equipment. They said they had requested new equipment in writing or fixed equipment in person, but wheelchairs had not yet been ordered by the provider. We asked the registered manager to follow this up so that there was some equipment to support people to mobilise. We followed this up after the inspection and were informed that three new wheelchairs had been ordered and delivered to the home.

Throughout the day we noticed the premises was in need of redecoration and refurbishment. In one person's room there was a piece of wood hanging from the wall above the head of the bed that we asked to be removed before it fell on them. We also fed back that the cupboard in the communal hallway had a broken lock and was left open with bottles of bleach and other cleaning chemicals lying on the floor that any person could have access to. We asked for a commode that was soiled from past use to be cleaned and

clinical waste to be disposed of as they were left in the bath in the communal upstairs bathroom.

The above evidence demonstrates a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We looked at care records and saw that there were some gaps in the understanding and recording relating to the MCA.

We saw that a DoLS application for one person stated the person did not lack capacity but the application was made. This was not needed if the person did have capacity and shows a lack of understanding of when a DoLS is required. We looked at a mental capacity assessment form for one person and saw it was signed on the service user signature section by the next of kin. This form had the sections to describe if there were any advanced directives and wishes or if there was a lasting power of attorney in place all ticked as no/not known. As such it was not clear if it is no or not known. We saw that relatives without lasting power of attorney had signed consent forms for individuals without the legal authority to do so. This included end of life decisions about whether or not to resuscitate individuals and decisions about finances.

We saw that care records were missing evidence that best interests meetings or discussions had taken place. There was no evidence of best interest decisions or a capacity assessment for two people on covert medicines. We asked the registered manager where evidence of best interests decisions were and were told that the discussions were happening but they were not recorded anywhere. The manager had a working knowledge of the principles of the MCA when asked, but staff had not been supported through training to update their knowledge about the MCA. We saw from training records that Deprivation of Liberty Safeguards training was to be completed every year and four care staff out of seventeen were in date for this training. Seven care staff had never attended it. The provider's practices were not in line with the legal requirements and principles of the Mental Capacity Act.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff training matrix 2015/2016 showed that training was out of date for training in dementia awareness despite needs assessments stating nearly every person in the home needed support around dementia care. There were no staff working in the home including the registered manager that had in date training as described by the home for challenging behaviour, nutrition and diet awareness and equality and diversity. Since the inspection the registered manager contacted us to confirm that care staff had been booked on training for moving and handling, infection control, first aid and safeguarding.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Seaforth Lodge nutritional screening and risk assessment stated policy as "The home shall ensure, through a restorative approach, that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied by dietary services." Every staff member we spoke with including the registered manager said the food was of poor quality due to the limited range that was ordered based on a strict budget. One staff member said "They don't buy and provide the food people want." Another staff member said they had bought fruit out of their own money for a person who did not like the food and another care staff member told us about the provider taking food away and telling staff to buy something else.

On the day of inspection we saw there were no fresh fruit or vegetables available in Seaforth Lodge. Service users could not access fresh fruit to snack on and the meals were not nutritious. Dinner on the day of inspection was chips and burgers with no vegetables or salad to accompany it. We asked if a range of food was offered and were told by care staff it was. We did not see any food in the fridge for alternative meals other than bread which had gone past its best before date and some milk. We observed lunch and saw that every person except one stayed in a chair in the lounge to eat, there were only four spaces at a table to eat in the communal area for a shared dining experience. For a person who needed their food pureed it was pureed as one whole meal rather than the ingredients separated so it did not look appealing

We saw in the communication diary an entry that recorded a dietician visited on 26 December 2016 and recommended that for two people they should have "more milky drinks, more butter in mash, double cream in porridge, extra yoghurt, and ice cream." Weight records showed that for one of these people their weight had gone down from 55kg in June 2016 to 47.5 kg in January 2017. This person was noted as at high risk of malnutrition. The follow up visit noted the dietician advice given on 7 January 2017 was "food fortification with cream, butter, nourishing drinks, puddings, ice cream, yoghurts, and weekly weights." On the day of our visit the two meals provided were not fortified with cream or butter. There was no cream, butter or yoghurts in the fridge to fortify meals. The advice from a health care professional was not being followed to ensure adequate nutrition. We informed the local safeguarding authority of our concerns that people were not receiving adequate nutrition.

We asked people if they could have a drink any time they liked, one person said "yes" and another told us "I have to wait until tea time they bring it then." We observed a person asking a care staff member for a drink and being told to wait until tea time. We intervened and asked the care staff member to get the person a drink if they were thirsty. We asked permission to enter one person's room to talk with them. They had a drink out of their reach across the room. We asked them if they would like their drink within reach, they said yes so we moved it where they could reach it. We asked the registered manager when people could have drinks, we were told that they had set "tea times" for drinks but if they were thirsty in between people could ask for a drink at any point.

The above evidence demonstrates a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at supervision records for staff and saw they were taking place regularly and were recorded with notes. Appraisals were starting to take place and more were booked in for future dates.

Individual files contained records of visits from medical professionals. However actions to meet healthcare associated needs were not always identified in care plans. Weight monitoring records showed there were gaps where the weight of individuals had not been taken in some months during the year. The advice to take the weight of an individual on a weekly basis had not been followed and they continued to be weighed monthly.

One relative we spoke with told us how their family member had become unwell and the home had sought medical attention for them and liaised with various health professionals to get a diagnosis. They told us this person was now on a different medicine and was feeling brighter and more alert since care staff and the registered manager had supported them to access health care services.

Requires Improvement

# Is the service caring?

## Our findings

People said the staff were caring. One person said "Anything you ask they come as soon as they can" and another person said "Very good not had any trouble with any of them." Relatives spoke highly of care staff and said they were happy with their approach but did notice they often seemed rushed. One relative said "The staff should be commended. It is a really tough job and they do a sterling job." Another relative said "Staff are always very kind and caring" and "staff are very pleasant and patient."

We observed interactions between people and care staff throughout the day. Care staff did not spend much time with people other than to complete a care task such as assisting a person to eat or passing them a drink. Care staff did show through their interactions with people they knew their preferences and carried on with conversations with people that were started earlier. The registered manager said "All my staff know all the people well, some people have been here for years."
People were comfortable with staff to ask questions and smile at them whilst they were providing care. We asked people if staff talked to them whilst they were giving assistance, people told us "Yes they talk to you all the time", "They come to you when they are not busy" and "There is a lot to see to." One staff member told us they bought a person oranges because they knew they liked them and wanted them to enjoy eating.

Throughout the inspection we observed the registered manager referred to people who required assistance to eat as "feeders". We fed back that this was not respecting those people and asked that the registered manager use the names of people. The registered manager agreed and said it was a habit and they will no longer do it. Documents were entitled toileting regime and shower/bath routine which were not dignified or respectful of people. We observed one person being told by care staff to "Drink your tea so we can go and change you" in the lounge where other people were sitting. When people were eating their mouths were wiped with toilet paper as there were no napkins available. We fed all of these examples back to the registered manager at the end of the inspection.

People did not always have their privacy respected. When we asked people if care staff knocked on their doors before entering they said "They just tap and walk in" and "Yeah they're alright."
We saw that one person became distressed in the communal lounge, the care staff tried to reassure them but they were getting more upset. The registered manager came over and asked if the person wanted to speak to their relative. The phone was set up for the call but put on loud speaker. The person could not get up and walk with the phone from where they were in the communal lounge because they were not mobile. The rest of the room could hear the conversation clearly and hear the private exchange between the person and their relative. The person became very confused and the relative became upset as they had not been told the reason for the call and were unprepared. Neither this person nor their family member had their privacy respected and were not given an option to conduct their conversation in a quiet area away from all the other people in the communal lounge.

The above evidence demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records and spoke to people to find out how much involvement they had in the planning of their care and support. We saw that many care documents were not signed by people. A relative we spoke with said they were involved in decisions about their relatives care and were kept informed if they became unwell or needed medical attention. When we spoke with people about the amount of choice and control they exercised in their day to day there were mixed responses. One person said "They come and ask you if you want to go to bed." We asked people if they had a choice over whether they had a bath, shower or wash in the mornings. One person said "They ask you which you want. I prefer a bath but I take a shower because it's easier." We asked them who it was easier for, they told us "Them, it's easier for the staff."

Requires Improvement

# Is the service responsive?

## Our findings

Staff and the registered manager responded when people became unwell or needed referring to a health care professional. The changing needs of people were responded to by involving different professionals to assess and then treat any new illnesses or conditions. We saw in care files input from different professionals and where family members had been contacted to keep them updated.
We asked the registered manager how people's needs were assessed and how they contributed to their care planning so that it was person centred and captures their likes and dislikes. The registered manager said "Each person is different, the approach is individualised." They told us each person is assessed by the registered manager or deputy manager before they come into the home and are asked what their likes and dislikes are. This assessment had not been fully completed in each care record we looked at, and also did not include people's preferences. The registered manager advised that this form, placed at the front of files, was relevant only to people when admitted and that information about people's needs were in their updated care plans. This was a potential cause of confusion about people's needs.

Individual care plans did not comprehensively identify people's needs. For example, the care plan of one person, whose relative was involved around their finances, did not identify how the person's money was being managed. The relative's involvement was evident only through correspondence in the person's file. Care plan goals were generalised in many areas of examples seen and actions to meet people's needs did not always provide specific advice to help staff carry out the identified need.

We asked people if they were having their spiritual needs met, they said "We have services here once or twice a week" and "I'm a Catholic I get a visit now and then [from the priest]."
Care plans did not include the wishes and preferences of people who used the service and were therefore not personalised. This increased the risk of staff not knowing about people's preferences and how to deliver care in a personalised way. We saw that some preferences were recorded, for example one person liked two pillows and another person liked to sleep with the window ajar.

Preferences for how often people showered or bathed were recorded. The home recorded when people were scheduled to have a bath or shower and whether this took place or not. We looked at the bathing and showering preferences for three people and looked to see if these were being met. Preferences for how often people liked to be bathed or showered were not being met for any of the care records we looked at. For example, for one person their needs assessment stated "prefers to have a shower rather than a bath at least twice a week." The record of baths/showers showed that this person had a shower/bath four times in November 2016, twice in December 2016, six times in January 2017 and once in the first week of February 2017. Across four months this person's preference for frequency of showering was not being met.

The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said "People sit and watch the box all day" and "I like reading they get me library books." We asked if people ever left the home and were told "No", "in the summer we are in the garden", and "[they have] taken

us out to the seaside into the country and that." Relatives we spoke with said "It can't be much fun just sitting there" and "They used to love singing but they don't do that now."

There was no evidence that people received a quality of service that gave people positive engagement in activities of interest to them and helped to enhance their sense of wellbeing. The registered manager told us the person who usually does activities was on leave. We asked who was doing them in the meantime and were told care staff were. Staff were very rushed and one care staff member tried to do a physical exercise activity. The activity lasted less than five minutes with each person encouraging them to do arm raises or catch a ball. One person said "I'm not doing none of that." The care staff member moved on to the next person without offering any alternative or exploring why the person did not want to take part. The television was on throughout the day in the communal lounge and people spent the whole day sat in their chairs with little or no stimulation. One person kept asking us to read with them as care staff did not have the time.

We looked for evidence that people contributed to how the service was run and their views were responded to through feedback or complaints. There was only one set of notes for a meeting for people who lived in the home dated March 2016 where food and activities were discussed. We asked people if the home held meetings for people to contribute their views and were told "I couldn't tell you" and "I don't know."

Relatives told us they had no concerns or complaints and would speak to care or management staff if they did. People said "You can complain to the staff", "I can speak my mind" and "They might do [respond] they might not." Complaints records showed that complaints were being logged and needs assessments amended when action was needed in response to a complaint.

Inadequate

# Is the service well-led?

## Our findings

The registered manager had carried out quality assurance checks to try to monitor and improve standards at the service. However, we found the governance systems in place were not operating sufficiently robustly to always identify and address improvements that were needed, in a timely and effective way. Monitoring procedures did not effectively assess, monitor and mitigate risks to people including their health, safety and welfare.

We identified that the monitoring systems at Seaforth Lodge failed to pick up gaps in risk and needs assessments outlining care needed for service users with diabetes. We found preferences were not being met in terms of how often people had a shower or bath. Documents relating to the Mental Capacity Act 2005 contained inconsistencies and in some cases relatives had signed to give consent where they did not have the legal authority to do so. Information on covert medicines was not clear on how it was going to be administered and best interest decisions records were missing. We found the registered manager was aware dietary needs were not always being met for people but had failed to mitigate the risk of this by not ordering additional food items such as double cream and yoghurts. We found that in the weight records summary 2016 records for monthly weights had gaps for every month in 2016.

On the document entitled toileting regime there were large gaps for when people had their continence needs met. The training matrix for 2015/2016 showed there was training in safeguarding, MCA, health and safety and equality and diversity that staff had not attended and were not in keeping with the provider's recommendation for renewal. Records for people who had passed away were not updated. The residents list we were provided with on the day of inspection and other daily recording sheets still contained details of two people who had passed away.

The registered manager completed most of the paperwork in the home because there were not enough staff on shift for time to be spared for completing care records. We saw there were not quality checks made by the provider on care or records to ensure care was of a high quality. This meant the registered manager was not appropriately supported to make improvements.

Staff were supported through supervision meetings but felt they were not listened to by the registered manager when they voiced concerns about the quality of the food and the need for more staff. Staff felt they did not have any input into the running of the home and they were disturbing the registered manager if they had any concerns.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager knew people and their needs and they recognised her but did not know her by name.

We found there was not a positive culture in the home, that relationships between care staff, the registered manager and the provider were not open. There was not a drive for improvement from either the provider or the registered manager and when we gave feedback about all of our concerns the seriousness of them was not fully acknowledged by the provider. When we made suggestions about peoples dietary needs not being met they said they would look into it and consider the feedback. After the inspection, a professional from the local authority quality team visited the home and peoples dietary needs were still not being met and fresh fruit and vegetables were still not available.

Staff had poor or broken equipment to provide care with and limited food to provide nutritious meals. Care staff and the registered manager were not equipped with the knowledge to provide high quality care. Basic training had not been attended by most staff and there was not the resources or support available to develop the care staff or the service so they could improve. The areas in need of improvement in Seaforth Lodge were wide ranging across all parts of the service.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider failed to provide care that was meeting service users' needs and reflecting their preferences.<br>9 (1) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider failed to ensure the service users were treated with dignity and respect. The privacy of service users was not always ensured.<br><br>10 (1) (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure care and treatment of the service user was provided with the consent of the relevant person or adhere to the principles of the Mental Capacity Act 2005.<br><br>11 (1) (3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider failed to ensure all premises and |

equipment were clean, secure, and properly maintained. Standards of hygiene were not appropriate for the purposes for which equipment was used.

15 (1) (a) (b) (d) (e) (2).

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<br><br>The provider failed to ensure that care and treatment were provided in a safe way for service users. The provider failed to assess the risks to the health and safety of service users of receiving the care or treatment, and to do all that is reasonably practicable to mitigate those risks. You failed to provide the proper and safe use of medicines.<br><br>12 (1) (2) (a) (b) (g). |

**The enforcement action we took:**

Warning notice

| 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<br><br>The provider failed to ensure service users were safeguarded from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. The provider failed to prevent restraint from being used that was not necessary or proportionate and care and treatment was degrading for the service user.<br><br>13 (1) (2) (4) (b) (c). |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The nutritional and hydration needs of service users was not being met. The provider failed to |

| | |
|---|---|
| | ensure that receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health. The provider failed to ensure receipt by a service user of dietary supplements when prescribed by a health care professional.<br><br>14(1) (4) (a) (b) (c). |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to establish and operate effective systems to assess monitor and improve the quality and safety of the service in carrying out the regulated activity. You failed to assess, monitor and mitigate the risks relating to the health and safety and welfare of service users. You failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment and decisions taken in relation to this.<br><br>17 (1) (2) (a) (b) (c). |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure there were sufficient members of suitably qualified, competent, skilled and experienced persons. The provider failed to ensure that persons employed by the service provider in the provision of a regulated activity were receiving such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform.<br><br>18 (1) (2) (a). |

**The enforcement action we took:**

Warning notice