Waterfall House Ltd

Seaforth Lodge

Inspection report

Carlton Road
New Southgate
London
N11 3EX

Tel: 02083612634

Date of inspection visit:
19 July 2017

Date of publication:
24 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

At our last inspection of this service on 7 February 2017 we found breaches of nine legal requirements. We rated the service as Inadequate and it was placed into Special Measures. We served five enforcement warning notices on both the registered provider and registered manager. These were in respect of safe care and treatment, meeting nutritional and hydration needs, safeguarding, staffing, and good governance. This report details the findings of a comprehensive inspection and also covers whether the warning notices have been complied with.

At this inspection we found improvements had been made in some areas of concern, the issues raised in the warning notices had been partly addressed. However, the service was still in breach of five legal requirements.

This inspection took place on 19 July 2017 and was unannounced. Seaforth Lodge is registered to provide accommodation with personal care for up to 21 people; at the time of this inspection there were 14 people living there. Seaforth Lodge is a converted house in a residential area of North London; it has a garden and is close to local amenities.

As a condition of its registration the provider is required to have a registered manager in place. There was a registered manager in post at the time of our inspection. There was also another registered manager who was not working as a registered manager but had yet to de-register despite our advice to do so. 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.

Supervision was taking place regularly and training courses had been booked to boost staff knowledge on meeting people's needs. Staffing levels had increased and there were extra staff in the morning at the busiest point in the day. People were having their needs better met because of the increase in staff; this meant there was no longer a breach in legal requirements in the area of staffing.

Improvements in the consistency of recording consent meant the service was now meeting legal requirements in the area of consent and in following the principles of the Mental Capacity Act 2005.

We found that efforts had been made to capture more person-centred information in care files and involve relatives more. Where people were not having their preferences met for showering and bathing at our previous inspection, some improvements had been made in this area. This meant that although there was still some improvement to be made, the service was no longer in breach of legal requirements around person-centred care.

However, safe care and treatment was not being provided and a continuing breach of legal requirements

was found in this area. Many times throughout the day people were put at risk of being given food that was not suitable for them, which placed them at risk of worsening health. People were also put at risk of pressure ulcers developing through not being repositioned regularly, and at risk of falling when mobility equipment was not used.

We also found a continuing breach of legal requirement in the area of premises and equipment. New wheelchairs and shower equipment had been ordered and equipment was cleaner. Despite this, the premises was not secure, with one ground floor window wide open throughout the day. This window and another on the first floor did not have a fully functional window restrictor fitted. This placed people at risk of an intruder climbing in through the window and someone falling or climbing out of the first floor window.

At our last inspection we found a breach in legal requirements around nutrition and hydration. At this inspection we saw professional advice had been followed in regards to fortification of food with cream and milk and butter where needed.

Staff told us they felt more supported since the last inspection. During the inspection there was insufficient oversight of the care being provided resulting in errors that affected people and put them at risk. There were no audits of people's daily care records and gaps not being identified. This resulted in a negative impact on people's safety. There was no quality assurance support from the provider for the registered manager. We found a repeated breach of legal requirements in the area of governance.
There were overall four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 arising at this inspection. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service therefore remains 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. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. People were placed at risk of having unsuitable diets when they had diabetes and at risk of choking by being given inappropriate foods and fluids.

We saw improvements in the cleanliness of the premises and equipment. New equipment had been ordered after the last inspection. However, people were not consistently supported to use the equipment they needed when moving, placing them at risk of a fall.

Some improvements had been made to risk assessments. However, risks were not always fully captured and some conflicting information remained in files. Staff had knowledge of safeguarding processes and there was a procedure for reporting any concerns.

There were more staff on shift to meet people's needs than at our last inspection.

Is the service effective?

Requires Improvement

The service was not effective. Deprivation of Liberty documents were in place. The service was now working in line with the principles of the MCA.

There was some fresh fruit and vegetables in the premises but it was not readily available for people to help themselves to. The mealtime experience we observed was not effective in supporting people to eat their food.

We saw improvements in training provided for staff after we served a warning notice for a breach of legal requirements in this area but staff still showed a lack of understanding and competence in some areas of care.

Is the service caring?

Requires Improvement

The service was not always caring. We observed some caring interactions between staff and people. However, we also observed interactions where staff did not address people in a respectful manner and did not knock on doors before entering

rooms.

People were not always involved in the planning or implementation of their care. Families had been asked in most cases for their input into care planning documents.

Is the service responsive?

Requires Improvement

The service was not always responsive. Stimulation provided throughout the day for people was limited. Most people spent most of their day in the same chair in the same position.

The care was not always person centred and people's life histories and preferences were not always captured. The care given was often generic rather than personalised. However, we saw an improvement in preferences for showers and baths being met.

There was a complaints policy in place and no new complaints had been made since our last inspection. Relatives said they knew how to complain.

Is the service well-led?

Inadequate

The service was not well-led. There was no structure in place for the provider to check the quality of care. Audits were taking place for some aspects of care but were not recorded and were missing some concerns we identified.

There was insufficient oversight of the day-to-day care provided for people. People were placed at risk due to lack of competence and lack of guidance from senior staff and the registered manager.

Staff said they felt more supported. Supervisions were taking place and staff meetings were more regular.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 July 2017 and was unannounced. The inspection team consisted 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.

We reviewed information we held about the service from previous inspections, notifications they had sent in to us alerting us of important events in the service and any feedback from key stakeholders received over the last six months. We also spoke with the local authority who had been working with the service to improve the quality of care.

During the inspection visit, we spoke with nine people using the service, and four of their relatives. We talked with four care staff and the chef and interviewed the registered manager. We looked at care plans and risk assessments for six people, and their daily care records. We looked at health and safety information, policies and procedures, staff files and complaints and safeguarding information.

We observed care in communal areas throughout the day and completed a Short Observational Framework Intervention (SOFI) during lunch and dinner. SOFI is a way of observing care interactions for people who may not be able to communicate with us because of their individual support needs. We also spoke with three health and social care professionals during the inspection process.

Inadequate

Is the service safe?

Our findings

At our last inspection on 7 February 2017 we found that risks were not fully assessed and people placed at risk of unsafe care and treatment. After the inspection we served a warning notice on the provider and registered manager for a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw an improvement in some aspects of risk assessments. For example, risk assessments around diabetes for two people now included what the safe blood sugar range was when tested and what the signs of them becoming ill with very high or low blood sugar were.

However, we saw across the day how the risk information for these two people was insufficient, placing them at unnecessary risk. The care documents for the two people with diabetes mentioned a diabetic diet but did not say what the diabetic diet was. During the inspection we saw the two people with diabetes repeatedly put at risk, for which we had to intervene. One person was offered a sugary dessert. We intervened and asked if this dessert was diabetes friendly. The person was then brought over yoghurt to eat that contained sugar. We asked a care staff member if this was a diabetes suitable dessert, they said yes and we asked them to go and check. The care staff member checked with another staff member who said "it is low fat it is ok for diabetes." We intervened again and asked the two staff members to check with the registered manager whether this dessert was appropriate according to the diabetic diet the person was on. The registered manager said it was fine. The registered manager then checked the packaging and changed their mind and said it did have too much sugar in it and the person was brought an alternative. In summary, we had to intervene with three different staff members before the person with diabetes was provided with a dessert option that met the requirements of their diabetic diet according to the registered manager.
Later in the day we observed the two people with diabetes being offered biscuits as a snack. Both people ate several sweet biscuits with chocolate and a sweet cream filling. A member of the inspection team asked the registered manager if the two people with diabetes could have biscuits. The registered manager said they could have one plain biscuit with no chocolate or filling. We informed the registered manager this was not what had been offered and they had both eaten several biscuits. The registered manager spoke to care staff and they said they did not know the two people had diabetes and were on diabetic diets. The two people were placed at risk of ill health through the actions of staff not being aware of the risks they faced and insufficient risk information being made available for them when serving food.
Some people were not being supported to have advice from professionals followed regarding their nutrition and hydration, placing them at avoidable risk of harm. One person was put at risk of choking. They should have been provided with a pureed diet with thickened fluids according to their care plan and instructions from a speech and language therapist. This person was given a puree with lumps of cauliflower in it for lunch and a serving of trifle which was not pureed and had lumps of sponge in it. Later in the day when a member of care staff took this person a drink of water they had not thickened it, putting the person at risk of choking on the water. We intervened and asked a senior staff member to prevent the person from choking; they asked the staff member to thicken the fluid. Some thickening powder was then added to the water, despite the instructions on the thickening powder container stating powder should be added to a dry cup then fluid added. The water was mixed and we saw it was full of large lumps where it had not been mixed properly. The care staff member took it to the person's room to help them drink it. We intervened again and asked the senior staff member to stop the person from being supported to drink something which had large

lumps in it and could have caused them to choke. This demonstrated that care staff had a limited understanding of how to mitigate choking risks for this person and were not aware of how to provide appropriate care that did not put the person at risk of choking.
We saw three people being put at risk when supported to move. One person who required the assistance of staff to move using a full body hoist was moved used a sling that was large in size. Their care plan stated they needed a small sling size to suit their frame. It took three staff members to support the person to be moved in the hoist. We asked one of them which size sling the person should be supported with and they said a medium. Staff were not aware of the correct size of sling to use and did not check before hoisting the person, putting them at risk of slipping out of the sling. Two other people were not supported to stand using the standing hoist when their care plan and risk assessment stated they should be supported to stand using the standing hoist. These people were placed at risk of falling and sustaining an injury.
People were placed at risk of developing pressure ulcers. For one person who needed to be repositioned every two to three hours, we saw them sitting in the same chair without a change in position from 07:30 to 14:15. We looked at this person's turning charts to see if they were being turned to manage the risk of a pressure ulcer and found several gaps in the charts in the days leading up to the inspection. The records showed that this person was not moved from at least 8.00 to 13.30 on the previous five days. This showed the person was not repositioned and the risk of the person developing pressure ulcers was not mitigated.
We fed back these concerns to the registered manager throughout the day and again at the end of the day when the provider was present. The registered manager said "it is a matter of me checking staff knowledge" and acknowledged that people were placed at risk throughout the day.
We checked protocols for PRN (as and when required) medicines and saw they were in place for most people, but two people did not have them. We asked the senior care staff member administering the medicines after the medicines round what one of the PRN medicines was for and they said for one person it was "for aggression." We could not find a document explaining what the signs of aggression were for this person and what should be tried before administering the medicine. This could have placed them at risk of being given the medicine inappropriately as staff did not have guidance in place.
We saw two medicines errors had been made and not identified. One error was for a person who required eye drops and after checking we found they had been administered but not signed for. We also looked at the controlled drugs record and saw that a controlled drug had not been signed for as administered making the stock balance incorrect. We fed this back and the error was amended.
The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We checked to see if medicines were administered safely. Medicines were stored in a lockable trolley and controlled drugs were stored in a separate lockable cabinet attached securely to a wall. Medicines requiring refrigeration were stored in a fridge that was within a safe temperature range. We saw some good practise with the administering of medicines where staff checked with people if they were in pain before offering pain medicines that were PRN. Files showed good covert medicines administration documentation and communication between the registered manager and GP to ensure the appropriate medicine was prescribed that could be crushed for people who needed it to be. During our observations of medicines administration we saw that people were being given their medicines as per the instructions on the prescription.
A warning notice, issued after the inspection on 7 February 2017 due to a failure to comply with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in the area of safeguarding, had been complied with. At the inspection prior to this one we found staff had not all attended training in safeguarding and we witnessed an incident that needed reporting as a safeguarding alert. At this inspection we saw most staff had now been on training and for those who had not it had been booked in for the week after the inspection. Additionally, safeguarding was now being discussed in staff supervisions and team meetings. The registered manager told us there were no new safeguarding referrals since our last inspection. The service was no longer in breach of legal requirements around safeguarding people.

At our last inspection in February 2017 people and relatives said there were sometimes not enough staff. We saw that staffing levels affected the care people were getting and they often had to wait or had their care interrupted. At this inspection we saw that an additional staff member was on shift in the morning during the busy period and the rota reflected an increase in the amount of care staff that were on any given day to support people. There were enough staff to meet people's needs during the inspection and people did not have to wait as long at mealtimes or to receive personal care because the provider had arranged to have more staff on each day. One staff member said they had seen the difference it had made to people through having more staff on in the morning, and a relative said "yes there is enough staff."

A warning notice issued after the inspection on 7 February 2017 due to a failure to comply with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been complied with. At the inspection prior to this one there were not enough wheelchairs to meet people's needs. Since then the provider had ordered new wheelchairs and these were now in use. Equipment was no longer soiled and a new bath chair and full body hoist had been acquired. Improvements had been made in this area to ensure equipment was now cleaner, safer and there was enough equipment to safely meet people's needs. We checked if care equipment was being suitably maintained and stored. Wheelchairs were suitably stored in a communal cupboard.

Staff told us of recent improvements including "repainting and making it more fresh" and "they have done work to make the home look better." Another staff member and one relative said some redecoration work had been done but the whole home needed refurbishment as it was old and run down. We saw some improvements in the décor of the premises and the kitchen and bathrooms had been repainted and deep cleaned. We did not see any disrepair in the property that might put people at immediate risk.
Early in the inspection we noted a window at the front of the property on the ground floor for someone's bedroom wide open. We discussed this with the deputy manager and expressed concern that it was open wide enough for a person to climb in from the outside or for a person to climb out from the inside. We asked the registered manager to show us two rooms upstairs. One window on the first floor did not have a working window restrictor on it. A window restrictor is a piece of equipment attached to the window to make sure it can only be opened wide enough to let fresh air in but not pose a risk to people if they tried to climb out or were at risk of falling out. We fed back to the registered manager that we were concerned people were at risk of falling from a height from the first floor window or an intruder climbing in the downstairs window. The registered manager said they would check all the windows the next morning.

The above evidence demonstrates a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
After the inspection we followed this issue up to see if it had been remedied. A week after the inspection the registered manager informed us all windows had been checked and the provider had ordered new window restrictors.

Recruitment processes were robust, including obtaining two references from past employers for new staff, an interview process, and obtaining a disclosure and barring service (DBS) certificate to show that applicants were safe to work with vulnerable adults. The registered manager told us that DBS certificates were being renewed for some staff as they had last been done over five years ago. Identification documents were in place to show that people were legally allowed to work in the home.

Requires Improvement

Is the service effective?

Our findings

A warning notice issued after the inspection on 7 February 2017 due to a failure to comply with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding consent, had been complied with.

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 spoke with staff and saw there had been improvements in consent records and staff had now been on training in this area. DoLS were in place and where conditions were stipulated they had been met. There was one full body hoist in a person's room that did not use it and a standing hoist charging in the bedroom of a person who did not use the standing hoist. These people would not be able to verbally consent when asked if the hoist could be stored in their room due to their communication needs. We asked the registered manager about this and they could not give a reason why these rooms were used other than they were spacious and confirmed that no consent had been sought for storing the equipment in these people's rooms. Despite these observations, on balance, the service was no longer in breach of legal requirements regarding consent.

A warning notice issued after the inspection on 7 February 2017 due to a failure to comply with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding staffing, had been complied with.

At the last inspection in February 2017 records showed that many staff had not attended basic training in courses that would have supported them to fulfil their roles more effectively. At this inspection we saw that staff had all either attended or had been booked on mandatory basic training covering areas such as dementia, nutrition, fire safety, MCA, and safeguarding. Staff said "It is helpful" and "it reminds us of the things we forget." People said of staff skills and knowledge, "They are well trained" and "I think they do very well. I have no problem with the staff. It is not an easy thing they do." Despite an effort to book staff on training we found improvements still needed to be made. Staff knowledge of people's diets and understanding of diabetes, choking, and dignity and respect when caring for people were lacking.

Supervision for staff was taking place and they said "supervision is helpful" and "I learn about how I can do things better." Staff said they felt supported by the supervision process and we saw that staff were being met with regularly and in line with the provider's policy on supervision.

A warning notice issued after the inspection on 7 February 2017 due to a failure to comply with Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding nutrition and hydration, had been complied with.

At the last inspection in February 2017 we saw that professional advice was not followed for some people who had specific dietary and swallowing needs. For people who had been assessed as being at risk of malnutrition their food was not fortified with cream and full fat milk and higher calorie foods were not provided. At this inspection there was cream and full fat milk and high calorie desserts being provided for people that required this. We also saw an improvement in the availability of fresh fruit and vegetables. At the last inspection there was no fresh fruit or vegetables available, at this inspection we saw oranges, watermelon and carrots in the building. However, we only saw one person offered fresh fruit throughout the day and there were no bowls of fruit for people to snack on. We asked the registered manager about this and they said they did not leave bowls of fruit out in communal areas because one person would eat them all.

Staff told us they had seen a marked improvement in the food provided. Relatives told us they were happy with the food, they said although the menu was not varied or exciting they felt people were having their nutritional needs met. People were positive about the changes to the food, they said "Excellent and I mean excellent with a big plus at the end. Especially love the porridge in the mornings" and "On the whole very good. I didn't like it once but I do now."

Staff and the registered manager were responsive to a change in people's health needs. We saw several referrals to mental health professionals and dieticians where there was a change in behaviour or weight loss. Relatives said "if there are any problems they phone me immediately" and felt when their relative became unwell the service was quick to respond.

Daily charts were not always checked, showing an ineffective system for monitoring people's health. For one person we had to intervene as we saw they had not had a bowel movement for nine days putting them at risk of ill health. We spoke with the registered manager who called for medical assistance from a GP to come and check on the health of the person at our prompting.

Requires Improvement

Is the service caring?

Our findings

At the inspection prior to this one in February 2017 we found the service to be in breach of legal requirements relating to dignity and respect. We found the language used by the registered manager and in care documents to not be respectful of people. At this inspection the registered manager treated people with dignity and the names of certain files had been changed to reflect a more caring approach. Despite these changes we observed several instances where care staff were not treating people with dignity and respect. Therefore the service was still in breach of this requirement.

We saw one staff member refer to a person as "good boy" and another said "she is usually such a good girl." This was not a dignified way to refer to another adult. During lunch we observed a staff member's impatience with a person. When they asked the person what they wanted for dessert, they did not give them time to respond and said "Talk, respond." The staff member then made the decision for them as to what they would eat. Staff frequently referred to supporting people to eat as "feeding" which again was not a dignified way to refer to the support that people were being provided with. We also saw examples where staff did not explain what care they were giving. One staff member put on a person's shoes and socks without explaining what they were doing.

During lunch some people were rushed to eat, with one person who was being supported to eat having large spoonfuls of food held closely to their mouth before they had finished swallowing the last one. We saw two care staff standing over people supporting them to eat, leaning in to their personal space rather than sitting next to them. Care staff did not converse with people during the mealtime other than to give them a command of "open your mouth", "have some water" and "eat some more" making the meal time focussed on a task rather than an enjoyable experience for people. One person had mashed potato on their face, but a staff member supported them to eat some dessert without first assisting them to wipe their face. The staff member then used a spoon to scrape the food off the person's face and gave them the mixed mashed potato and dessert in one mouthful. This demonstrated failures to treat people with dignity and respect. We fed this back to the registered manager and provider and they said they would consider further support and training in supporting people to eat and dignity in care training.
For another person whose care plan stated for food to be cut up into small pieces and softened, we saw they had their food mashed up into a thick puree. This person was also supported to eat by staff with a spoon from the start of lunch, despite being able to do this themselves. We asked staff why the person was not eating independently and why their food was mashed up; they said it had been like that for at least five months. We then asked the registered manager why the support provided was different from the care plan and professional advice given. They said the person could eat independently most of the time but did sometimes require staff support if they became distracted. We fed back the person had their food mashed and was supported to eat from the start of the meal with no time given for them to try to eat themselves. The registered manager said that staff were not following the care plan in relation to nutrition. This could place them at risk of inappropriate care and was not treating the person with dignity to not allow them to eat independently and with puree rather than cut up food.

After lunch we observed two people were wet and needing continence support to change. Both people had

been sat in chairs all morning in the lounge; staff had not noticed that one person was wet, despite walking past them several times. This person was displaying signs of distress; we intervened and asked staff to help them as they were unable to manage their own continence themselves. The approaches to these people's continence needs was not dignified.

We saw in two people's rooms equipment was being stored and charged in there, despite the people not needing that equipment and it being used for other people. People had not been consulted on this decision and this was confirmed by the registered manager.

People told us staff did not always knock on their doors before entering; one person said "The only thing I don't like is they don't knock on my door. This is going to change as I will put a lock on the door." Another person said "The women never knock on the door but [another care staff member] always does." We saw on two occasions where staff did not knock on the bedroom doors of people or announce themselves before they entered. We asked the registered manager if staff had been on training around dignity and respect and they said they had not but after our feedback they would look into this.

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

Although some people said staff did not knock on doors a relative told us they always saw staff knocking on the bathroom door when supporting people with personal care or continence needs.
Feedback from relatives was that people were "generally well looked after" and the "staff attitude is really good." People told us they liked care staff, and "they are alright yes."

When we spoke with staff they talked of people with fondness and were caring in their approach. One staff member said "I love caring for the elderly" and every staff member said they enjoyed their job. The evidence detailed above showed staff would benefit from training in the appropriate way to speak with and about people who needed support and how to support people in a dignified way.

Religious needs were noted in care plans and a local priest had been visiting the home for a person who had recently passed away. We did not see any meals on the menu that reflected cultural preferences despite people living in the home coming from a diverse cultural background.

We fed back at our last inspection that people and relatives did not have much involvement in the planning of care and very few of the care plans had been signed by people or their relatives. At this inspection we saw an improvement in this area and that relatives had been involved in recent reviews and their opinions taken in to consideration.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in February 2017 the service was in breach of legal requirements regarding person centred care. People were not having their preferences met in how often they liked to be bathed and showered. At this inspection people said "I wash every morning and shower occasionally" and "I have a shower once a week." We saw that efforts had been made to ensure people were having their preferences met for bathing and showering. The showering and bathing rota showed that people had set days where they were scheduled in to have baths or showers and these were normally being met. However, one person's care plan stated they were supported every morning to have a wash and were to be prompted in the afternoons to have a shower. We did not see any record of this prompting and the rota showed they had had a bath or shower three times in the first 19 days of July 2017. Their schedule on the rota did not match up with being prompted for a shower daily.

Care files were not always person centred and details of what people did before they came to the home were missing, such as past careers, family history, and likes and dislikes. These were recorded for some people but not all, meaning some people did not have their historic preferences met as staff were unaware of their histories. Throughout the day we saw a lack of insight from care staff into how people's needs should be met through their diets and the consistency of their food, how their continence needs could be met and how they could be supported to be more independent and how they liked to spend their time.

At the last inspection people were not provided with stimulation throughout the day and sat in the same chairs for most of the day. At this inspection we saw staff sitting down with some people for a few minutes at a time to do jigsaws or read the paper. We observed these interactions were with people who could communicate with staff and respond to them. People who were without verbal communication sat in the same position in the same chair with little or no stimulation and were often sleeping or staring. There were double doors leading onto a pleasant garden from the lounge. We did not see one person encouraged or supported to go out into the garden for fresh air or a walk. One person wanted to go into the garden and staff told them they were not allowed as a member of the inspection team was in the garden. We intervened and said the person could come into the garden if they wished to. We asked the registered manager if there were any activities planned for that day other than staff sitting with people for a few minutes at a time, they said there were not. Although there had been some improvement in how staff engaged with people, what was on offer was not aimed at people with more advanced dementia or who could not provide verbal communication with staff, and the range was limited.

We asked people what they did during the day, they said "We do virtually nothing. I play my music in my room. I like to read my books. I do see some silly games played" and "Listen to the radio or watch TV. I just watch what they others are doing, if anything." When we asked if they ever went out of the home people said "Basically we stay in the home" and "We go out the hospital I think."

Details of how to complain were on display in the hallway and staff were confident in how to support a person to make a complaint if they needed to. People said they would complain to the registered manager. One relative said they felt they could feed back to the registered manager and provider if there were any

issues. The registered manager told us there were no new complaints since our last inspection; the complaints records reflected this.

Inadequate

Is the service well-led?

Our findings

Seaforth Lodge had two managers in place who had registered with the CQC; one of them was fulfilling the role of registered manager whilst the other was in post as the deputy manager. Both registered manager and deputy were in post at our last inspection. We had advised for the deputy manager to de-register in February 2017 but this had not yet been completed. At this inspection we found that issues affecting the quality and safety of care were still wide ranging, although improvements had been made in some areas. We asked the registered manager how they had made changes to the quality assurance process in the service to make improvements to the care provided and pick up concerns earlier. The registered manager told us they wanted to start using a new audit process so they could delegate more but this had not been introduced and no clear improvements had been made in picking up issues with care provided since our last inspection. Audits were taking place for medicines administration but failed to pick up two errors we found on the day of inspection.

There was evidence that oversight of the care given was not adequate and this contributed to people being placed at risk of avoidable harm when eating and drinking. Throughout the day people were not treated with dignity. These issues around avoidable risk of harm and dignity demonstrated the service was again breach of legal requirements despite feedback after our last inspection and support from the local authority. We also saw that oversight of daily records was not taking place to enable gaps in recording to be identified and identify developing welfare risks. This lack of oversight also contributed to people being placed at risk of avoidable harm with repositioning records showing people were not turned enough to mitigate the risk of pressure ulcers developing. Bowel records were not monitored effectively to pick up when a person was at risk of ill health due to not opening their bowels over an extended period.

We fed back to the provider that the registered manager had little support in monitoring and improving quality. The provider responded they would now introduce an area manager to check the quality in services. This was the second time we had fed back regarding this issue as we had found the same concerns at our previous inspection in February 2017.

Warning notices from our previous inspection had not been adequately complied with and there were repeated breaches of regulations relating to safe care and treatment, dignity and respect, and premises and equipment. The care we saw during the day repeatedly placed people at risk and there was inadequate oversight of care and records and the improvements relating to our previous inspection.

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

During the day we observed that when the registered manager was present in communal areas with people they demonstrated they knew people's needs well and people knew them and reacted warmly when they approached people. When we intervened, the registered manager spoke to staff immediately and challenged them on their practise. During the lunch period the registered manager supported people to eat and showed a caring practice that was a good example to care staff. However, care staff had not followed

the example that had been set and the knowledge from registered manager to care staff had not been passed on. Care staff told us they felt supported and they could now go to the registered manager with any concerns but they still found the registered manager very busy.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure the service users were treated with dignity and respect. 10 (1) (2) (a)

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to 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. 12 (1) (2) (a) (b) (g).

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure all premises and equipment were secure and properly maintained. 15 (1) (b) (d).

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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. 17 (1) (2) (a) (b) (c) (e).

The enforcement action we took:

Notice of Proposal to cancel registration