

Prime Life Limited

# Seacroft Court Nursing Home

## Inspection report

Seacroft Esplanade  
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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

### About the service

Seacroft Court Nursing Home is a residential care home providing personal care to up to 50 people. The provider has decided to no longer provide nursing care. The service provides support to older people, some of whom may be living with dementia. At the time of our inspection there were 33 people using the service.

### People's experience of using this service and what we found

The home had been rated as requires improvement for the last three inspections. The provider had failed to ensure a high standard of care was embedded in the home.

People were not always supported to express their individuality. Family members reported people's laundry was not always returned correctly and people sometimes wore clothes that were not their own. People's bedrooms were not always personalised to represent their lives and interests.

People raised concerns that staff did not always respond to the bell immediately. The registered manager had identified this as a concern and had recruited more staff. Records showed that going forwards they would have more permanent staff to ensure the standards of care were maintained.

In addition, attention had not been paid to all areas of the home which needed cleaning. More housekeeping staff had been employed to help with this issue.

Staff received the training and support needed to enable them to provide safe care. This included training on how to keep people safe from harm and how to raise concerns. They felt able to raise concerns with the registered manager and were confident that their concerns would be taken seriously and acted upon. Recruitment practices at the home ensured staff were safe to work with people who might be made vulnerable.

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

Risks to people were identified and care was planned to keep people safe. When incidents occurred, action was taken to keep people safe and to reduce the risk of similar incidents. Medicines were safely managed and available to people when needed.

The registered manager had audits in place to monitor the quality of the care provided. They had identified the concerns we raised, and action had been taken to improve the care people needed.

The registered manager worked collaboratively with health and social care professional to meet people's needs.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was requires improvement (published 2 December 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

#### Why we inspected

The inspection was prompted in part due to concerns received about infection control and staffing levels. A decision was made for us to inspect and examine those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well led sections of this full report.

#### Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-led findings below.

# Seacroft Court Nursing Home

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection team consisted of two inspectors and an 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.

#### Service and service type

Seacroft Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Seacroft Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

#### Notice of inspection

This inspection was unannounced.

#### What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

We spoke with 5 people living at the home and 1 family member and a visiting friend. We also spoke with the area manager, the registered manager, two care workers and the chef. We spent time observing care to see what it was like to live in the home. We reviewed a range of records. This included 6 people's care records and multiple medication records. We also looked at a variety of records relating to the management of the service, including policies and procedures.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

### Staffing and recruitment

- People told us staff were supportive but not always able to attend to them immediately. One person said, "They always come, if they've been a while they apologise, they've been doing something else." People also raised concerns as they felt the standard of care they received dropped sometimes. .
- We raised this with the registered manager who was aware of issues with staffing. The provider was able to evidence more staff had been recruited to work in the home.
- Staff had received ongoing training and support to ensure they had the skills needed to provide safe care to people. Systems were in place to prompt staff when their training was due. Records showed staff had complete the appropriate training. Staff told us they felt supported by the registered manager and had regular meetings to discuss any training needs or concerns they had.
- Recruitment processes ensured that staff were safe to work at the home. The registered manager ensured that references were checked, and staff had a Disclosure and Barring Service check done before they started to work at the home. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

### Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at the home. One person told us, "Yes I'm fine, my medical needs are served well." A relative told us, "Yes, I know [Name] is being looked after."
- Staff had received training in how to keep people safe from abuse. They understood the need to raise concerns immediately to the registered manager. In addition, they also knew they could raise concerns outside of the home environment. However, staff were confident that they would not need to do this as they were certain the registered manager would take action.
- Where concerns had been raised the registered manager had worked collaboratively with health and social care professionals to keep people safe.

### Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were identified in people's care plans and care was put into place to keep people safe. For example, people's ability to move around the home was assessed and where people needed equipment to support them this was in place.
- Where people's illness impacted on their ability to recognise boundaries and risks, care plans were in place to guide staff how to keep them safe. For example, some people raised concerns about a person living with dementia who walked around and would go into other people's rooms. The registered manager had put increased observations in place to monitor this person to keep them and other people safe.

- Incidents were assessed, and action taken to reduce the risk of recurrence. For example, when a person fell, healthcare professionals were contacted to see if any changes were needed to their care. Incidents were analysed for trends so action could be taken if similar incidents were occurring.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

#### Using medicines safely

- Medicines were safely managed and available to people when needed.
- The provider had an electronic system in place to help staff manage medicines safely. Staff who administered medicines had received training in how to do this safely to reduce the risk of errors. The registered manager completed competency assessments to ensure staff were working in line with their training to keep people safe.
- Some people had medicines, such as pain relief, prescribed to be taken as required. Guidance was available for staff to support them to administer this medicine consistently. For example, one person's care plan noted that they were not always able to tell staff they were in pain. The guidance contained information what other signs staff should look for which may indicate the person was in pain. This meant the person would receive medicines consistently to manage their pain.

#### Preventing and controlling infection

- The home was mainly clean with no malodours.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

The provider was supporting people interact with their friends and family. In line with the government guidelines on visiting in care homes, there were no restrictions on visitors to the home.



# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The provider and registered manager had a set of audits in place to monitor the care provided. They had identified the issues we found at the inspection and the registered manager had taken action to improve care. However, the home had been rated requires improvement for the last three inspections. This showed the systems in place were not effective in driving and embedding improvements in care to the standard people should expect.
- People's needs and dignity were not always put at the centre of the care provided. Before and during the inspection concerns were raised about people's clothing not being returned to them from the laundry. One relative told us their loved one was wearing another person's clothes. This had been identified as a concern in a recent dignity audit and the registered manager was taking action to ensure clothes were returned to the right person.
- People's dignity and individuality was not always supported. For example, there was a lack of personalisation of bedrooms when families were not available to, or chose not to, support people to make their room feel like home. Additionally, in the lounge all the chairs were around the sides of the room, so people could not easily sit in friendship groups and talk to one another.

Systems had not been established to drive improvements in the home This placed people at risk of receiving a poor standard of care. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had taken action to comply with the regulatory requirements. They had notified us about events which happened in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had systems in place to take into account people's opinions of the service they received. This included reviewing care plans with people and their relatives, regular correspondences with relatives and professionals and an annual survey. People told us they would raise concerns with members of staff in needed.

- Relatives were kept up to date with their loved one's progress, outcomes and any incidents that may have occurred. A family member told us if they had any concerns they would contact the registered manager.
- No duty of candour incidents had occurred. However, the registered manager was able to demonstrate their understanding of duty of candour and any action they would need to take after an incident.
- Information was shared with staff through team meetings and handover sessions. Staff told us they felt confident to raise any suggestions or feedback to their line manager.

Continuous learning and improving care; Working in partnership with others

- The registered manager had investigated accidents and incidents and had identified areas where improvements could be made. They ensured this learning was shared with staff and used to improve the quality of care provided.
- The registered manager worked collaboratively with health and social care professionals to ensure people received care which met their needs.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had been requires improvement for the last three inspections, Systems were not in place to sustain and embed improvements.</p>