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

Overall summary

This was an unannounced inspection on 02 December 2014. We did not give the provider prior knowledge about our visit.

This inspection was brought forward during to concerning information we received from other agencies direct to the Care Quality Commission (CQC).

Seacroft Court Nursing Home provides accommodation for persons who require personal and nursing care and can receive treatment and screening procedures to help maintain their health and well-being. It can accommodate 50 people. At the time of our inspection 34 people were using the service. People were of mixed ages and some people were suffering from dementia related illnesses.

At our last inspection on 26 June 2014 the service was not meeting two regulations. They were staffing and record keeping. The provider sent us an action plan telling us what they were going to do to ensure they complied with the regulations.

The service had a registered manager who had been in post since April 2014. A registered manager is a person

Summary of findings

who has registered with the Care Quality Commission (CQC) to manage the service and has legal responsibility for meeting the requirements of the law, as does the provider.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves and others. At the time of the inspection no people had had their freedom restricted.

We received information of concern prior to the inspection about the standard of hygiene and the possible lack of infection control methods within the home. We therefore decided to look at the infection control standards within the home at this inspection.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. The information and guidance provided to staff in the care plans was clear.

Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. However, some of the risks associated with people's care needs were not always assessed and planned for and no action plans were in place.

People told us they were happy with the service they received and staff treated people with respect and were kind and compassionate toward them. People and the relatives we spoke with told us they found the staff were approachable and they could speak with them at any time if they were concerned about anything. They said they had limited contact with the manager.

Staff told us they had the knowledge and skills that they needed to support people. They did not receive all their training in a timely manner and on-going support to enable them to complete training was fragmented.

The provider had systems in place to regularly monitor, and when needed take action to continually improve the quality and safety of the service. Not all audits had been completed and some did not have action plans so it was difficult to see when tasks has been completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

The people we talked with said they felt safe.

Staffing levels were monitored to ensure adequate staff were available to meet peoples needs.

Attention to detail to ensure the premises were safe and free from hazards was not monitored regularly.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People told us they had access to other health and social care professionals.

Staff took time to ensure peoples meal choices were taken into consideration.

Staff responded to peoples individual needs and ensured they communicated with other health professionals.

Requires Improvement

Is the service caring?
The service was caring.

People told us staff protected their dignity and privacy.

Staff were spoke people quietly to people about their health care needs.

The care plans recorded peoples needs.

Good

Is the service responsive?
The service was responsive.

People told us they had had no reason to make a complaint.

Individual's needs were being met and requests fulfilled where necessary.

When people were ill staff acted quickly to get other health care assistance from GPs', nurses and hospital assistance.

Good

Is the service well-led?
The service was not consistently well-led.

People using the service told us they did not see the manager.

The provider had an audit system in place which was not always completed at this location.

Action points from meetings, comment cards and audits did not always have completion dates.

Requires Improvement

Seacroft Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 02 December 2014 and was unannounced.

The inspection team consisted of four inspectors.

We also spoke with the local authority and the NHS who commissioned services from the provider in order to get their view on the quality of care provided by the service.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection.

During our inspection we spoke with nine people who lived at the service, two relatives, a visitor, 12 staff members, who were care staff, trained nurses and ancillary staff, and the registered manager. We also spoke with three other Prime Life Limited staff who were visiting the home that day. Some people could not make an informed decision to speak with us so we undertook three short observational assessments. This is called a Short Observational Framework Inspection (SOFI). We also undertook some general observations of people who used the service and staff through out the inspection.

We looked at 10 people's care plan records and other records related to the running of and the quality of the service and including staff records.

Requires Improvement

Is the service safe?

Our findings

The people we talked with said they felt safe. When we asked one visitor if they felt their relative was safe at the home, they initially said yes but then went on to say, "Although if you are talking about safe, [named relative] has managed to have three falls in the three months she has been here." When asked if staff had explained to them how the falls had happened, they said they hadn't and they were unsure how the falls had occurred. Another visitor told us they had never seen anything to give them cause for concern.

In the care plans some people had been identified as frequently falling or stumbling due to their poor mobility. Each one had a plan in place to ensure staff knew how to make a safe environment for them and gave instructions on what mobility aids to use. The provider had a system in place to analysis falls but this had not been completed since August 2014. It should be completed monthly, according to the provider's policy. We saw staff encouraging two people to walk with a frame and staff walked with them until the person was walking safely.

Staff told us how they would react if they saw anyone being abused. This covered the current guidelines for protecting people. Staff also told us how they ensured people's diverse needs were being met; such as a person's need to observe religious practice and protecting a person's gender identity. We saw on the staff training planner that staff had received training in how to keep people safe within the last two years.

The provider made appropriate referrals about incidents and accidents to ourselves and the local authority safeguarding team. They showed where they had taken appropriate action to safe guard people from harm. Contingency plans were in place to ensure staff knew what to do if utilities such as electric and gas supplies failed.

At our last inspection we found that the provider could not tell us how they had arrived at the staffing levels at the home and people told us there were not always sufficient staff to meet their needs. The provider sent us an action plan. They told us they would be liaising with the commissioners of services to ensure the current support level reflected peoples needs. Commissioners confirmed to CQC this had taken place. At this inspection there appeared to be sufficient numbers of staff deployed throughout the day to meet people's needs.

Visitors told us there was generally enough staff on duty to provide the care people required. A relative told us they didn't see staff in communal areas but went on to say staff were busy with other people who were needing individual attention. We did observe staff in communal areas but not all the time. Senior staff confirmed the staff were in bedrooms or on breaks during those periods. We sought out staff and confirmed the comments by senior staff.

When asked about staffing levels one person said, "Well that is a bit of a problem." They told us they waited between 10 minutes and half an hour for their call bell to be answered. One person said, "It just depends what is going on. They have other people to look after and it takes a while if they are busy getting someone up." Another person told us, "They have a few more members of staff now, before they were rushed off their feet."

We saw the staffing structure audit which had taken place in October 2014. The manager told us they informed head office of the dependency levels of people using the service and head office staff put together details of what staff would be required each month. The October 2014 audit showed more care hours were provided than required. The manager assured us this information was still current and no changes had to be made. Staffing levels had recently been increased with care assistant staff coming on duty at hours to reflect when they were needed the most.

Recruitment of staff took place locally but the manager was assisted by head office staff. Senior

staff explained the recruitment process and how they were involved in interviews. Newly recruited staff told us how they had obtained employment and the safety checks made on them prior to them starting. This followed the provider's policy on recruitment. We did not see any staff files as they were held at head office.

Systems were in place to ensure people received their medicines in a safe and timely way. Staff showed us how medicines were ordered, stored, administered and disposed of in line with guidance on the safe use of medicines. Medicine records had been appropriately

Requires Improvement

Is the service safe?

completed and staff were knowledgeable about how people liked to take their medicines. We saw staff spoke discreetly with people about their needs for medicines and provided them with the time and support they needed.

Staff were trained to give medicines and also attended meetings with the clinical lead at the home who discussed issues such as; record keeping and people's needs. Staff monitored the temperature of the medicines storage room and medicines fridge. We experienced the temperature within the medicines storage room as being very warm and staff told us this was a common experience. This could result in medicines not being kept at the required temperature to ensure they were safe to use. The room was also used to store other office equipment which non clinical staff accessed at times. On two occasions we saw the room was left unlocked. There was a risk medicines were not being stored in a secure environment.

One person told us they kept their medicines in a locked cupboard in their room. They said they informed staff when they needed a repeat prescription and staff ordered their medicines in a timely fashion. Two other people told us they received their medicines on time each day.

People told us their rooms were kept clean and tidy and they were happy with the levels of cleanliness in the home generally. One person said, "I'm a little unsteady in my walking but I know I can move safely around the home." We looked in four people's bedrooms, with their permission. They were visibly clean and the mattresses were in good condition. Communal areas such as sitting rooms, bathrooms and toilets were clean. In one bathroom there was damage to the floor which made it difficult to clean and another was in a poor state of repair. These bathrooms were in use at the time of the inspection. A temporary repair was made to flooring in a corridor area during our visit.

A staff member told us there was a daily cleaning schedule and a schedule for deep cleans of the rooms. These had been signed to indicate they had been completed. Staff told us the carpet shampooer had been out of service for three to four months and they did not know when it would be back in service. This meant there were constraints on cleaning the stair carpets. Rotas had been recently changed to ensure sufficient housekeeping staff were on duty to maintain the cleaning schedules.

The kitchen was visibly clean and tidy. There was separation of cooked and raw foods. The steam washer was out of order on the day of the inspection. We were told the maintenance department was waiting for a part. Staff were hand washing crockery which meant items were washed at a lower than ideal temperature.

There were systems in place for the disposal of waste. However, we found the container supplied by the contractor and used for the disposal of clinical waste did not have a lid. Yellow bins used to store waste awaiting collection outside the home were not locked as required. This was observed by the inspection team.

The manager was ensuring that the home was maintained and cleaned. If any repairs were required the provider confirmed they had received notifications from the manager. We saw that all equipment had valid safety certificates. Regular fire equipment checks were made and fire drills recorded. An infection control nurse and trainer had recently been appointed. They told us they had arranged four training sessions for staff to attend infection control training. They had also attended a recent meeting held by the County Council to improve their knowledge.

Requires Improvement

Is the service effective?

Our findings

We asked people if they liked the meals. One person said, “My only gripe is that you don’t get your five a day.” They told us they had not been asked their likes and dislikes and didn’t think they could ask for anything other than what was on the menu. Later when we talked with the chef they told us there had been a four weekly rotational menu but they had recently gone over to a weekly one and had started introducing more variety. They told us they had been experimenting with offering a Chinese meal recently and most people had enjoyed it but a small minority said it was spicy. The chef was going to continue offering this type of food as an alternative to the more traditional menu. Copies of people’s nutritional care plans were kept in the kitchen for kitchen staff to refer to and the chef appeared familiar with people’s needs.

People told us hot drinks were served mid-morning and mid afternoon and there were hot drinks and snacks in the evening. We saw a selection of cold drinks available in the sitting room areas. We observed staff offering hot and cold drinks to people. People told us they enjoyed the food and drinks provided for them. Comments included, “The food is really good” and “He [the chef] cooks the food lovely.” One person had mixed views about the meals and said, “You get your good meals and not so good. "During the lunch time meal we saw the chef speaking with people about the meal; asking if they wanted extra portions and helping them to make choices.

A visitor told us their relative had lost weight since they had come to the home. They told us staff had ensured they had been referred to a specialist to see if there was a medical problem. They told us their relative had been provided with nutritional supplements which was confirmed by the chef. This showed that the provider had worked with other agencies to ensure the person received a nutritional diet.

People told us if they were unwell staff would call a doctor. We observed staff making arrangements for other health care professionals to visit. They gave a brief history of the person’s condition and then gave instructions to other staff on how to monitor the person’s condition before other assistance arrived. The care plans recorded when people had been seen or advice sought from other health care professionals. Care plans were updated and checks made when required and showed the provider was ensuring staff were monitoring people’s needs.

When a person had problems with the integrity of their skin staff had responded by ensuring adequate cover was given to the persons’ legs. Instructions were in place on how the person was to be moved in bed. The integrity of the person’s skin was also recorded on the turn charts which were completed by staff every time the person was moved. Staff were following the recommendations of a tissue viability specialist.

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Is the service effective?

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The manager was not fully aware of those people who had Do Not Attempt Cardiac Resuscitation (DNACPR) forms in place as instructed by people's GPs'.. One staff member said, "We just know." Information had been included on the staff handover sheet but was not accurate as we found two people's names, with forms, who were not on the list. This was immediately rectified by staff. We were unsure whether staff had fully explored whether the correct best interests decisions had been made before the DNACPR forms had been completed.

We looked at the nine DNACPR forms. Three were completely correct. In the other notes there were different aspects which were not complete. This included. Sections of the forms not completed by the medical practitioner, review dates missed, place of death not completed. We informed the manager immediately and had confirmation the following day that all had been or were in the process of being reviewed.

Staff told us training was available. They said it was often difficult to access this as staff shortages meant they needed to work with people who used the service and ensure their needs were met. The training chart showed large gaps when staff had not completed training, such as; emergency first aid, continence awareness, falls prevention and food safety. Some staff were not recorded as receiving induction despite being employed as long ago as March 2014, April 2014 and May 2014. Staff had however received other training after their induction period. They told us this was sufficient for their current needs and covered the types of conditions and problems of people who currently lived in the home but recognised they would have to attend update sessions as soon as they could.

Staff said that supervision times were hard to fit in with staff shortages and although they could voice an opinion there were mixed views as to whether those opinions were valued. One staff member said, "Its more about them telling us what we should be doing rather than a two way event." The supervision and appraisal planner for 2014/ 2015 gave months through out the year of when people would receive supervision, appraisal or medication supervision. We could not confirm whether all sessions had taken place as staff could not remember when sessions had occurred.

Good

Is the service caring?

Our findings

People gave us positive views about the staff. One person said, “Staff are ok. They look after me well. I have no complaints.” People said staff were gentle when providing care and checked with them before providing care. One person told us, “Staff are all very caring, they will do their best if you ask for anything and they will try to get it.”

Visitors also gave us positive comments about the staff. One visitor said, “Staff are very good, they are very nice and very conscientious.” Another visitor told us, “They [staff] are all good. They don’t single any one out, they treat us all fairly.”

We observed staff knocking on bedroom doors before entering. People told us they always did this to preserve their privacy. People told us staff also ensured curtains were drawn when helping them with personal tasks.

Staff told us how they supported people to make sure they were appropriately dressed and their clothing was arranged properly to promote their dignity. We observed staff ensuring ladies skirts were arranged well when they were sitting in a chair and after using a toilet. Staff did this without causing embarrassment to the person.

During lunch time we saw staff spoke with people in a warm and friendly manner. They made sure their attention was directed towards people and not towards any other tasks. They sat with people when they helped them to eat and encouraged them to use cutlery appropriate to their needs.

At other times during the inspection we saw the interactions between people and staff were mutually respectful and people were relaxed in the company of staff. Staff were laughing and joking with people in an appropriate manner. They made comments to people on how well they were dressed, how their hair had been styled and how well a certain coloured jumper suited a person. This all enhanced people’s mood as they smiled and giggled back but also thanked staff for their comments.

People were supported to be as independent as possible. We saw them being encouraged to do as much for themselves as they were able to. Some people used items of equipment to maintain their independence such as walking frames and wheelchairs. Staff knew which people needed pieces of equipment to support their independence and ensured this was provided when they needed it.

Staff however were task orientated for a part of the day. Staff referred to completing tasks, such as; toileting times, feeding times for those with dementia and “doing” turns. This appeared to be later in the morning. But we did see staff attend to people’s needs as they arose. When call bells were sounded staff responded immediately. One member of staff was allocated to the sitting room where most of those suffering from dementia sat and walked. They spoke with them, helped them with a jigsaw and played games.

Good

Is the service responsive?

Our findings

There were mixed views from people about staff talking to them about their care and being able to choose when they got up and went to bed. One person told us they had definitely been speaking with staff about their care and had free choice about everything. Other people could not remember being asked about their care needs or being involved in their care plan.

People told us if they were unhappy they knew they could make a complaint. No one who we spoke with had a reason to do so. People could not remember being given information on how to make a complaint. The complaints process was on display at various points around the home. The complaints log showed when complaints had occurred and whether the outcomes had been satisfactory to people. The manager told us they were exploring other ways to ensure people were aware about the complaints process. This would involve other written and spoken versions being available. They already had access to an translation service but had not had occasion to use it.

Staff were observed encouraging people to eat their meal and chatting with them. Staff who came into the sitting rooms did not interact with people and the people themselves were withdrawn and passive. In the dining room the interaction with people and staff was more positive. This is called a Short Observational Framework Inspection (SOFI).

Two people were doing jigsaws on the day of the inspection and both said they enjoyed doing them. One person told us they had a daily newspaper delivered. People told us there weren't many group activities but sometimes a person came in a mini bus to take them to a garden centre but places were limited. One person said, "They don't take us out at all. Going out for a couple of hours would do us good, a nice bit of fresh air would be good." Another person told us they didn't like group activities and preferred their own company. Some people were being provided with holy communion during our inspection. Staff had asked people what they liked doing and their interests and this was recorded in the care plan. Activities were mainly centred within the home.

There was a lack of involvement with the outside community. People told us they had been told they could go out but would have to contribute to the running costs of the mini bus. This was not always possible for some people and they did not want to use the emergency funds of the home to contribute. Staff told us people would not be asked to contribute if they did not have the means to do so.

We looked at five care plans in detail. The care plans were in the process of being reviewed. Staff had included in the new ones how they had responded previously to the needs of people and how currently a person's needs were being met. This included responding to a person's skin condition when they were resting in bed so they did not cause themselves damage. And ensuring a person's weight loss was being monitored and suitable referrals made to other health professionals.

Staff had responded to one person's need when they asked to be able to make drinks in their bedroom. The care plan showed the person's capability had been assessed prior to the kettle being placed in the room. There were on going assessments to ensure the person knew what they were doing. The person said, "I can make a drink and so can my visitors."

Some people had mental health problems and staff had recorded in the care plans when support had been asked from the local mental health team. Visits had been arranged in the home and in local clinics. Where medicines had been changed this was recorded on the medicines administration sheet. Care plans included how staff could ensure the person was not suffering from social isolation. As people's needed often changed on a daily basis staff had put safe guards in place to ensure they could respond quickly.

However we found on one care plan that staff were not always fulfilling the instructions given to them. One person who required hourly turns should not have been turned on to their back, according to advice from other health professionals. The turn charts recorded they were placed on the left and right sides and their back. Staff on duty could not tell us why other staff had done this. The manager told us they would they would investigate the incident and ensure staff were aware of how to look after this person. We saw instructions being given during our visit.

Requires Improvement

Is the service well-led?

Our findings

The provider return information (PIR) stated the manager had an open door access policy, people were unaware of this. People using the service told us they didn't see the manager. One person said they did not know who the manager was.

Resources were available for the manager to access by the provider to help them develop the team and drive improvement. Regular visits were made by head office and regional staff to see if they could help the local team. People told us those representatives spoke with them and they felt able to express their views. Staff also said the regional and head office teams were evident in the home and spoke with them and gave encouragement.

Job descriptions and staff hand books ensured staff were aware of their responsibilities. Staff told us they had read them and felt able to express their views to any member of the team.

A quality assurance risk matrix is being developed by the provider to identify risk areas and develop subsequent action plans, this was as a result of advice from commissioners of services. An action plan covering areas such as falls audits, electrical equipment failures, reviewing activities and a staff supervision planner was submitted after the inspection. Each section had dates for completion and who was responsible for carrying out the tasks identified.

A number of monthly clinical audits were undertaken for areas such as pressure ulcers, diabetes and weights. The diabetes audit enabled trends to be identified and action to be taken such as referral to the diabetes nurse for medicines reviews. However, the pressure ulcer audit did not have a clear action plan. Medicines audits were carried out monthly internally and an audit had been carried out by the supplying pharmacy in October 2014. Most of the actions identified had been addressed. This highlighted for the provider what actions staff were required to take to ensure medicines administration was safe.

Call bell audits had been carried out in October and November 2014. These indicated that 58% of calls were answered in under five minutes but 21% of calls had a response of over ten minutes. Relatives told us they had often used the call bell for their family member but at certain times of the day staff took longer to answer. No explanation had been given to them why this had happened. People told us staff would eventually answer their call bells but sometimes it seemed a long wait. The provider told us they were putting a new call bell system in place where they would be able to identify more clearly why call bells were sometimes not answered promptly. This would give a clearer picture of people's needs, staff deployment and times which were busier than others.

There were currently no audits taking place of care plans as all care plans were being re-written using a new format. The provider had a plan in place to finish every one by the middle of December 2014. They told us they were on target. This would ensure people's needs had all been recently reassessed and staff had a clearer picture of what people required them to do.

The provider had sent out comment cards for people to respond to. This covered areas such as care needs being met, standards of cleanliness and staff attitude. 67 comment cards had been sent to people who used the service and their families, but only 12 returned. These were broken down as four excellent, three good and three poor. There was no information on why people had rated the home poor or action taken as a result of the comments.

Records of staff meetings showed there was opportunity for them to discuss issues within the home; such as the correct use of slings and responses to call bells. The actions needed were recorded but we could not identify any information to show if actions had been carried out or were effective in resolving issues.

Staff told us they would like some better arrangements in place to help them discuss matters with a clinical lead. Each day there was only one nurse on duty through a 24hour period. The clinical lead was not included in the staffing level numbers and was not always in the building. They told us they felt vulnerable at times as they did not have any one else to go to for advice. This was being addressed by the provider in liaison with other homes within the group.

We looked at the maintenance file and safety checks had been carried out to ensure the building and equipment was safe to use. This included; the lift, hoists, nurse call system, fire alarms and emergency lighting. We looked at the maintenance log book and saw issues had generally been signed as completed. An outstanding item for

Requires Improvement

Is the service well-led?

replacement was a hand rail in the disabled toilet which had not been corrected for nearly a month. This meant this toilet could not be used unless the person was capable of standing unaided.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.