Mr Kevin Gunputh

Seabourne House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection visits took place on 3 and 10 January 2019 and the inspection was unannounced. We continued to receive information until the 16 January 2019. This inspection was carried out due to concerns that were raised with us. The provider was responsive to these concerns and worked transparently with CQC and statutory agencies to address issues raised.

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

Seabourne House Care Home is registered for 48 people. There were 37 older people living in the home at the start of our inspection. People had a variety of care and support needs related to their physical and mental health. The majority of the people living in the home had needs associated with the impact of dementia on their health and well-being.

There was not a registered manager in post, which is a requirement of the service's registration. 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. The provider had acted to recruit to this role. The last registered manager had left the service in November 2018. An interim manager was in post and a new manager had been appointed.

We received concerns and allegations in relation to whether people's needs were being effectively met and how well-led the home was. We reviewed this information and planned to carry out an inspection focusing on the questions, is the service safe? and is the service well led? During the inspection, we also identified that there were some issues related to oversight so we looked at all the domains to check the experience of care people were receiving.

Overall people's rights were protected, however staff had mixed understanding of the application of consent and best interests decisions. The provider acknowledged this and had put measures in place to support staff.

Recording relating to some risks was not always robust. This meant the monitoring of people's wellbeing and the risks they faced could not be achieved. This was addressed during our inspection.

People were supported to eat enough to obtain a balanced diet. People's dietary needs were met although preferences were not always respected.

There were sufficient staff to meet people's needs. Feedback from people and observations indicated that deployment needed to be reviewed and the provider committed to undertake this work.

Overall, people and relative's complaints were taken seriously and used as an opportunity for learning and improvement. However, one complaint had not been fully responded to and one person's concerns had not been fully addressed. The provider acted on this.

People's needs were assessed and their needs planned for. Care plans had not all been updated to reflect changes to people's needs and this impacted on meeting DoLS conditions. This had not impacted on care and staff were consistent in their understanding of people's needs.

People were supported by staff who felt supported and valued their training. Staff had the support and training they needed to meet people's identified needs.

People were supported by staff who promoted their independence and respected their dignity. People's independence and wellbeing was also enhanced by the design and environment of the home.

People received the care and support they needed and in the ways they preferred. Staff took the time to get to know people and their life and social histories. They used this information to help them understand the person and to provide appropriate care and support.

People were engaged with, and enjoyed, activities including individual and group activities. Most people and relatives felt that they were listened to and their views were considered and acted upon.

The environment was clean and well maintained.

There was a programme of quality checks and audits to monitor and improve the quality and safety of the service. The provider reviewed their processes in light of concerns identified and were transparent in their acknowledgement of learning. The registered provider took immediate action in response to the shortfalls identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risks were not always managed effectively. This was addressed during our inspection.

People received their medicines as prescribed.

People were supported by staff who understood their responsibilities to protect people from harm. Safeguarding practices were followed effectively.

People felt safe and there were enough staff to meet their needs. The provider committed to reviewing staff deployment in response to feedback.

Is the service effective?

Good

The service was effective.

Staff did not all have a clear understanding of the implementation MCA. The provider was in the process of addressing this.

People had access to healthcare when needed.

People's needs had been assessed and they were cared for by staff who understood these needs.

Is the service caring?

Good

The service was caring.

People were supported in ways that respected their skills and preferences and promoted their dignity.

Staff developed relationships with people and took the time to get to know them individually.

Is the service responsive?

Good

The service was responsive.

Care reviews largely reflected changes in people's experiences

although we found some examples where they contained out of date information.

People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary.

People enjoyed a range of activities.
People were cared for with compassion at the end of their lives.

Is the service well-led?

Good

The service had been through a change in leadership. A new manager had been appointed and an interim manager was in post when we visited.

People, relatives and staff had confidence in the management and spoke highly of the support they received.

There were systems in place to monitor and improve quality including seeking the views of people and relatives. Whilst these had not been effective in highlighting and addressing all the concerns identified during our inspection the management were robust in their responses and were able to see how they would identify these concerns.

Seabourne House Care 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.

The inspection was prompted in part by allegations of insufficient staffing, oversight concerns and poor care practices that put people at risk. Whilst incidents were subject to further investigation by the local authority safeguarding team, the information shared with CQC about care practices indicated potential concerns about how people's needs were met and how well the service was led. This inspection examined those areas. Early evidence indicated that the oversight of the service was not as robust as it had been when we last inspected. We opened the inspection up to check if this had had an impact on people's care.

The inspection site visits took place on the 3 and 10 January 2019. Our first visit was unannounced. The inspection team on the first day was made up of two inspectors. On the second day the team was made up of two inspectors, an assistant inspector and a Specialist Advisor. The specialist advisor provided clinical knowledge. We received information from relatives up until the 16 January 2019.

During our inspection we observed care practices and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people living in the home and spoke with or received feedback from relatives and friends of ten people. We spoke with 11 members of staff, a member of agency staff, the manager and three representatives of the provider organisation. We also looked at records, including medicines' administration records related to nine people's care, and reviewed records relating to the running of the service. This included four staff records, quality monitoring audits, the minutes of meetings and accident and incident records. We received requested information throughout the inspection. Following the inspection, we received further information as agreed with the inspection team.

We also spoke with social care professionals and health professionals who had worked with the service.

Requires Improvement

Is the service safe?

Our findings

Staff were able to describe with confidence the risks people faced and people's views were taken into account with regard to risk management. However, we found that monitoring of some risks people faced was not robust when we started our inspection.

Monitoring records related to people's fluid intake was not recorded accurately and it was not possible to tell if people had met their daily target and on some days people who needed to maintain their hydration because they were living with identified health risks that required this were recorded as having insufficient intake. Whilst their health outcomes suggested that this was a recording failure it was not possible to be confident of this. We spoke with manager and two provider representatives about this. They addressed this with the staff team and when we returned the staff were recording sufficient fluid intake and understood the need to do this accurately to support people's well being.

Two people had been put at risk because their care plans were not adequately followed. One person had been left with access to a known allergen and electrical sockets had not been covered in areas that another person who had an identified risk related to this was known to access. When raised with the provider these situations were addressed immediately and measures put in place to reduce the risk of these situations reoccurring.

The majority of risks people faced were managed appropriately. Care documents reflected the views of people and their loved ones with respect of risk management associated with mobility, falls and skin integrity. One relative described how their loved one's well-being had improved resulting in less falls since they had moved into the home. Staff were confident in the support people needed to reduce the risks people faced whilst living life the way they chose.

People received their medicines as prescribed. We observed medicines being given by staff who were trained, and assessed as competent, to do so. The staff supported people to take their medicines in ways that suited them; communicating effectively and respecting the way people were feeling at the time. One person's dementia meant that they at times became agitated and did not want their medicines at the time the staff were doing the majority of people's medicines. The person made this clear and the staff member respected this and returned at a later time. The medicine was not time dependent. Some people needed to have their medicines given to them disguised in food or drinks so that they did not know they were taking medicines. Where this was the case robust protocols had been followed to ensure this was necessary and safe.

Medicines were usually stored safely and securely at a temperature that maintained their effectiveness. We noted that some medicines were stored in a room that was not clean which raised risks associated with infection control. We raised this with the manager and provider who arranged for cleaning and then renovation before we left the site. We also noted that drinks thickener was left out on the first day of our inspection. This could have been accessed by a person living in the home and if ingested could have caused harm. This was addressed robustly by senior staff between our two visits. Care plans provided the

information staff needed to give medicines in a way that people preferred and to understand how they expressed pain if they could no longer ask for pain relief verbally due to their health needs.

People told us they felt safe and relatives also largely shared this view. One person told us: "Oh yes, I feel safe." A relative commented on the "exceptional" attentiveness of staff that kept their loved one safe. Most people could not communicate with words about their experience of care. They appeared relaxed and cheerful around staff indicating their comfort and ease.

People were supported by staff who understood how to identify signs that someone may be being mistreated and were confident in their understanding of what actions to take if they had concerns. Where safeguarding concerns had been identified the senior team worked openly with statutory agencies to ensure people's safety. There were policies in place to support good safeguarding practice and staff had received training in this area.

There was a system in place to ensure that incidents and accidents were reviewed, analysed and plans put in place to reduce the likelihood of reoccurrence. For example, fall care plans were revisited if people had further falls and changes made to reflect any identified factors. Where trends were identified deeper analysis had been undertaken to find the root cause. We identified three examples of incidents where we could not see appropriate actions recorded. Whilst when investigated by senior staff we found that the risks to people had been minimised, two opportunities for staff support following people having falls in difficult environments, may have been missed.

One of the concerns raised suggested inadequate staffing levels impacting on people's care. We reviewed rotas, observed staff and spoke with staff, people and the senior team about the deployment of staff. There was a staff compliment that was sufficient to meet people's needs. In addition to care staff there were staff who carried out specific tasks such as cleaning, food preparation, and laundry. These staff worked closely with the care team. The rota indicated that staffing levels were maintained at the levels determined by the provider and people were observed to be supported with care at times that reflected their wishes. The inspection team observed that staff appeared busy and moved quickly between areas of the home. This was acknowledged by people and visitors to the home who made comments such as: "Sometimes staff are a little pushed but they never let the residents want for anything." And "Sometimes staff do not come for a long time when I ring my bell." We were not able to review the call bell times for this person's room due to the nature of the system. The system was scheduled to be renewed to allow closer analysis of staff deployment. We spoke with the provider who told us that they would review and further analyse how the staff were deployed.

The service had an appropriate recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Appropriate information had been gathered to ensure that any agency staff working in the home had been safely recruited and had the skills they needed.

Staff received training in safety processes and practices such as moving and handling, fire safety and infection control and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. People's rooms and communal areas were cleaned throughout our inspection. A potential infection control issue was highlighted within concerns raised. The provider investigated and addressed this immediately describing their findings with inspectors and safeguarding professionals transparently. Whilst due to appropriate cleaning there had not been an infection control risk the practice did not reflect good practice and changes were made immediately.

Equipment owned or used by the registered provider, such as specialist beds and hoists, were suitably maintained. Effective systems were in place to ensure equipment was regularly serviced and repaired as necessary.

Good

Is the service effective?

Our findings

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We reviewed the care plans of two people who had conditions attached to their DoLS authorisations. Conditions are legal requirements that must be met to ensure the DoLS remains lawful. We were not able to evidence that these conditions had been met within the time frame of the DoLS. The provider identified that in one instance the record of a medicines review may have been archived and acknowledged that another person's condition was not now possible and that they needed to raise this with the local authority that had issued the safeguards. We saw that whilst the conditions had not been evidenced as met the person's medicines had been reviewed.

Staff demonstrated mixed understanding of the application of the MCA. They told us they checked with people before providing any care and explained what they were doing. They were less certain of the legal framework surrounding care for people in their best interests and how to record these care interventions. Despite some uncertainty staff were clear about not being restrictive in their support and we saw that care guidance supported the promotion of choice and this translated into the support that was observed. We discussed this with the provider and they acknowledged that the staff team had lost confidence in this area. They identified the measures they had taken to address it including staff support and guidance and a change in the recording options on the electronic recording system to allow for identification of best interest decision making.

People told us that staff had the skills they needed to support them. One person told us: "The staff are very kind and helpful." A relative told us: "The staff are very knowledgeable and well trained in dementia care so are able to meet the needs of the residents very effectively." Staff told us they felt supported by their colleagues, the manager and the provider representatives. They commented that they had access to valuable training to support them in their roles. One member of staff commented: "The training is brilliant." All staff commented on the availability and supportiveness of senior staff.

Newer staff had also had the opportunity to undertake a robust induction training. If staff needed to undertake the Care Certificate this was available. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. Agency staff also undertook an induction process when working in the home. There had been substantial recruitment to the staff team over the few months prior to our inspection. This

had led to a review of support for staff during this time and agreement had been reached to ensure new staff were supported by an identified member of the team who was not working on shift. The staff team feedback indicated this plan would be beneficial to the induction process.

People were supported with their day to day health needs in conjunction with health care professionals. We saw liaison took place with people's GP's to ensure the most appropriate treatment. We received feedback from a health professional who told us that their team held the home in high regard and had confidence in the competence of the staff team in making appropriate referrals and following through on guidance given. Records showed that people had regular contact from a range of health professionals such as: nurses, GPs, physiotherapists and consultants. Emergency health care was sought appropriately.

The physical environment was used in a way that supported people to maintain relationships and spend their time meaningfully. People in all parts of the home used communal areas and their bedrooms; there were also quiet places throughout the home for people to meet with friends and family. The environment reflected current good practice guidance in relation to dementia friendly environments. There were bright and contrasting colours to help people find their way around. There were also lots of items, such as scarves and bags placed around the home to provide focal points. Snack and drink stations had been placed in areas that people who walked independently were likely to stop at.

People were supported to eat safely. People were asked about what they liked to eat as part of their assessment process and this included any dietary, cultural or religious needs. People received the support they needed to eat and we observed that for those who ate in the communal dining room this was a social experience with staff providing support whilst chatting with people if this was appropriate. Some people preferred to eat in their rooms and they received their support and food without delay.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs. The process ensured that within the framework of needs catered for by the home, people were protected from discrimination from initial contact onwards. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. One relative observed that this process had been good. They told us: "Moving in was well organised. They came and did a full assessment."

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was being continually developed. There was a call bell system which people could use to alert staff if they needed them. This was scheduled to be upgraded to allow for more useful monitoring. The provider had introduced an electronic care planning system. The use of this system was being enhanced at the time of our visits. Information and recording options were being added to make the system more person centred and accurate. We met the member of staff who championed this system for the provider they explained the changes they had implemented through liaison with the organisation who provided the system. They were working with staff in the home to develop their skills and confidence with the system.

Good

Is the service caring?

Our findings

At our last inspection, we found the question, how caring is the service? Outstanding. However, at this inspection the service had not been as consistent in its support and care for people. This is why we have changed the rating for this question from outstanding to good.

Throughout our inspection there was a welcoming atmosphere in all parts of the home. We observed care staff, housekeeping staff and managers interacting with people in a caring, respectful and compassionate manner. Feedback on the caring nature of the staff team was provided by relatives and people. One relative observed how patient the staff were and we received comments such as: "I think they are so kind in their care." and "…most of the staff show great empathy". Relatives also commented on the respectful nature of the staff team and we observed that care practices upheld people's dignity.

However, people and relatives also reflected on staff being "busy" and "rushed". One person commented that they felt upset when staff spoke to them in a way they felt was abrupt as a result of this. A relative observed that their loved one had been upset as they had lost something. They explained that this distress had been unnecessary as the item could have been replaced easily as a spare was held in the office. We spoke with the senior management team about this; they explained that their initial investigations in response to concerns raised had identified the person-centred focus of the home was not at the outstanding standard previously achieved and now aspired to. They described actions taken to address this.

People felt cared for by staff. We heard comments such as: "The staff are lovely." The relatives we spoke with said they could visit the home at any time and always felt welcome. One relative spoke of their experience: "I was struck by the positive atmosphere and family feel."

Staff told us they enjoyed their work and enjoyed spending time with the people living in the home. They spoke about people with care and compassion. They all described their motivation for their work being the people living in the home making comments such as: "I love my job." They also spoke with respect for their colleagues. One member of staff told us: "We are passionate about care. Staff know their values and constantly go above and beyond their role. Staff genuinely care." We observed this warmth in many interactions that we saw during the course of our visits.

People were encouraged to use all the communal areas of the home. People using the communal lounge were relaxed in each other's company. We saw that staff took time to sit and talk with people in the lounges and visiting people in their rooms. Some conversations were familiar and light hearted and this was clearly appreciated by people. We spoke with staff about people who could no longer communicate easily with words due to the impact of dementia. Staff described how a combination of their facial expressions, movements and noises communicated how they felt and what they might need. This understanding was especially evident during a meal time when staff took cues from people and supported them with respect.

People's bedrooms were personalised with belongings, such as furniture, photographs and ornaments. People were encouraged to make decisions about their appearances including what clothing, jewellery and

makeup wore. People appeared well cared for throughout our visits and staff supported them with their personal appearance through the day.

Care plans reflected what people needed to retain their independence and the impact of staff support was evident throughout our inspection. Staff could describe what people could undertake themselves and the individual support they needed. Care plans supported this with an emphasis on the parts of tasks people could undertake for themselves and how they may communicate when they needed assistance.

People's personal relationships were supported. Most relatives told us that their relationships were supported and that they were made to feel very welcome. The expression of sexuality was supported by the provider's policies required staff to work in ways that respected people's human rights and promoted equality. Staff had all received training to support their practice in promoting dignity, respect within a framework of equality and diversity.

Good

Is the service responsive?

Our findings

At our last inspection, we found the question, how responsive is the service? Outstanding. However, at this inspection the service had not been as outstanding in its responsiveness. This is why we have changed the rating for this question from outstanding to good.

People and relatives spoke positively about the care and support received and made comments such as: "Residents are given individual care plans detailing their needs, likes and dislikes, with input from the resident and next of kin, and they are continually updated and this is reassuring for a (family member) who's (parent) is now in residential care."

At the last inspection, the service was very person centred and focused on people's strengths and abilities. This focus had continued with care plans detailing personalised information about people's needs and preferences and was supported by our observation of the relationships between staff and people. Compliments received reflected this personalised response. One expressed gratitude for the time staff had spent finding out want made their loved one "tick". Relatives mostly spoke highly of the personalised service their family members received. However, we received feedback indicating that in some parts of people's lives the highest standards of person centred care were not currently evident. One person explained they had not been asked what they wanted to eat and staff commented that their meal was a surprise. Another person's care plan had not been updated to reflect changes in their spiritual needs and we observed that a person had lost their hearing aid. When we asked about this the aid was found in their room. They had, therefore, been without it unnecessarily.

One of the concerns raised with the CQC related to the time people were able to get up. The provider had begun to review this concern prior to our initial visit. They identified that this was a concern that needed further understanding and had begun discussions with staff to understand the issues involved. A robust response was developed including support and input for staff around best interest decision making and recording.

Each person had a personalised plan that detailed how they liked to spend their time and what they liked to do. People had access to a wide range of things to do and ways to spend their time. Relatives all commented positively on how engaged their loved ones were, making comments such as: "There is a full programme of activities within a pleasant social atmosphere, there is always something going on in the lounge area.." Another relative commented on the opportunities for trips out. People who spend their time in their rooms by choice were visited by staff who knew their interests and what mattered to them.

Communication needs were identified at assessment before people moved into the service. These were recorded in the care plan and this meant staff had information about people's needs and were able to use this information to support people appropriately. This information was shared with relevant professionals. The systems in place reflected the Accessible Information Standard which highlights the assessment, recording, flagging and sharing of information related to people's communication.

Complaints information was displayed throughout the home. Most people and relatives/visitors we spoke with did not raise any concerns or worries. Records showed us complaints and concerns had were addressed and used as an opportunity to learn and improve the service. The person who had not been given a choice of meal told us their concerns regarding food choice had been raised previously and not been addressed adequately. The person agreed for us to raise this with provider representatives, who assured us they would address this immediately. Another complaint received in May 2018 had included reference to staff being unable to get a person up until the afternoon due to staffing levels. This was not the main focus of the complaint and had not been addressed through the process. An opportunity to review the deployment of staffing and its potential impact on people had been missed.

If people chose to they had a care plan which outlined their wishes and choices for the end of their life. When appropriate the service consulted with the person and their representatives about the development and review of this care plan. We saw positive feedback from relatives of people who had died in the home. One referred to "such amazing care" and another reflected on how beneficial a memorial service held in the home had been.

Good

Is the service well-led?

Our findings

At our last inspection, we found the question, how well-led is the service? Outstanding. However, at this inspection the oversight of the service had not been as effective in achieving consistent quality outcomes for people. This is why we have changed the rating for this question from outstanding to good.

The home had been through a period of leadership change. Since our last inspection the registered manager had left the service in November 2018. A new manager had been appointed but had not yet commenced their post. An interim manager was leading the service. People, staff and relatives were positive about the registered manager who had left but also told us they were confident with the interim manager. One relative commented: "The home has continued to be run to the same high standards."

The provider acknowledged that following the last inspection there had been a change in the oversight at the home and that this had potentially contributed to the current shortfalls in the quality and safety of the service. The senior management team were present in the home when we arrived unannounced on the first day of the inspection. They had started to investigate concerns raised and had a robust plan to increase the support for the staff team whilst addressing identified issues.

During the inspection we identified that a number of issues had not been responded to sufficiently due to a decrease in robust oversight. Information held in incident and accident forms had not led to recorded actions ensuring the quality of the service was maintained. The reviewing of people's satisfaction with their food did not always include people's feedback. Reporting had been identified as insufficient and whilst work had started on this the recording of fluid intake and continence care was not sufficient to monitor safety.

The management team were frank and open in their discussions with the inspection team and we were able to explore whether the issues highlighted would have been identified by internal quality assurance had the concerns not been raised. Prior to the information being received the provider had met with senior staff in the home who were experiencing a lack of confidence in their roles. The manager had also been liaising with the provider about areas of practice that they had identified required additional support. This included staff confidence around consent and recording issues. The provider had increased their supervision, support and oversight as a response to these communications and had started to explore the root cause of these concerns. The provider was confident that as these processes were followed the majority of the issues raised would have been identified.

The registered persons were very responsive and took immediate actions in response to our feedback throughout the inspection. They shared their improvement plans and committed time and resources to ensuring shortfalls were addressed immediately. Staff were all confident in the senior team and told us they could discuss any issues with the manager or provider representatives. They told us they felt listened to and that information was shared with them. Staff had attended a meeting following the first day of our inspection during which they had been informed of the current concerns and been afforded the opportunity to share their views.

There were quality assurance and monitoring systems and systems for seeking the views of people, relatives and staff in place. Actions were taken in response to any shortfalls found in audits and or from feedback from people, relatives, staff, professionals and there continued to be a focus on improving the service. We looked at previous quality assurance reviews and saw they had been effective in identifying areas for improvement and ensuring actions were taken and monitored, Changes were made to the oversight systems in response to this inspection as the provider identified opportunities to enhance the opportunities for staff to feedback.

Registered persons are required to send CQC notifications about any allegations of abuse and other events. We use such information to monitor the service and ensure they respond appropriately to keep people safe. Notifications had been made in line with the guidance given to providers.
The latest inspection rating was displayed on the provider's website and in the entrance of the home.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual access to computer based records and the inspection team were given access to records in line with legislation. Rooms containing records were locked when not occupied by staff.