Buckinghamshire County Council

Seeleys House Short Breaks Centre

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 June 2017. It was an unannounced visit to the service.

This was the first inspection of the service since the provider registered with the Care Quality Commission (CQC) on the 5 May 2017 to provide accommodation and personal care. However, the service is not new. Previous providers managed Seeleys House Short Breaks Centre when it was called Seeleys House Respite Centre. The previous provider was supported by the current provider (Buckinghamshire County Council) to improve and then a decision was made for Buckinghamshire County Council to manage the service fulltime. We had concerns about the service under the previous provider.

Seeleys House Short Breaks Centre is a care home for adults living with a learning disability and or physical disability. The home provides respite care. This means people often stay one or two nights. On day one of our inspection eight people were staying overnight and on day two, seven people were staying overnight.

The service did not have a registered manager in post. 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. A manager was in post who had been seconded from another service until a new manager was appointed. They had submitted an application to become registered with CQC and at the time of the inspection the application was being progressed.

At this inspection we found the service was not well-led. Quality audits did not routinely highlight failings. The service did not have a current fire risk assessment. Buckinghamshire Fire and Rescue visited the service and had issued the provider with a deficiency notice. The provider had not ensured the building was safe to be used as routine maintenance was not carried out. No Legionella risk assessment was on site to review and no water sampling had been undertaken. Water temperatures recorded highlighted there was a growth risk of Legionella. However no remedial action had been taken. The provider has since commissioned urgent testing and has provided us with a copy of their risk assessment.

Risks to people were not always assessed, mitigated and prevented. This was because pressure sore risks and risks around the use of bed rails were not considered. Care plans did not always contain information about risks posed to people as a result of their medical condition or support required. For instance one person was a diabetic and staff had not received training or had any guidance on how to provide safe care to them. Other people were at risk of choking but the risk assessment did not provide a detailed management plan to ensure staff were consistent in managing that risk. The provider responded to our concerns and after the inspection we received confirmation of training and actions planned to improve risk management.

People's human rights were not protected as staff did not fully understand the Mental Capacity Act 2005

(MCA). Staff did not always refer people who had restrictive measures in place to protect them from harm to the local authority (Supervisory Body) for an assessment of deprivation.

People were not supported to provide consent to care and treatment in line with the code of practice of the MCA. This was because consent was sought from family members who did not have legal authority to act on the person's behalf. Where a person did not have a legal representative, decisions about their care should be made with relatives or professionals in the person's best interest. There was a lack of understanding of the 'best interest' process.

People were at risk of not receiving person centred care. This was because care plans did not always refer to the person. A number of care plans we looked at referred to the person as X. Care plans provided an outline of people's needs but some care plans lacked the detail as to how staff were to support them.

Records were not suitably maintained, up to date or fit for purpose. Some records were kept in a generic communication book, which made it difficult to have a full overview of what support people had received. People's records were not always named, dated and we found information within two care files viewed related to another person.

Accident and incidents were not properly managed and filed appropriately. This meant accidents and incidents were not reviewed and action taken to prevent reoccurrence. Staff told us they had spoken with external agencies about incidents and accidents; however they could not demonstrate where that conversation had been recorded. This meant we could not confirm incidents or accidents had been managed appropriately.

There was a lack of managerial oversight and management of the service. Staff had been delegated tasks without adequate support and training to support them. For instance, staff had not received training on risk assessments or their keyworker role. Staff acting in a senior role had not received staff management training.

Staff were committed to providing a quality service and we recognised the work which had been undertaken to make improvements to the service. Staff spoke passionately about their work. We observed good team work throughout our inspection.

Staff had good knowledge of people's needs, likes, dislikes and preferences. People had developed close relationships with staff. People appeared relaxed and happy in the company of staff. We observed mixed practice from staff and communication with people could be improved.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found breaches of the Care Quality Commission (Registration) Regulations 2009. 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 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.

People were not always protected from harm. Staff were trained in safeguarding but senior staff did not always recognise what required reporting to the Local Authority safeguarding team.

People's likelihood of experiencing injury or harm was not routinely reduced because risk assessments failed to identify all risks posed to people.

The service operated robust recruitment to ensure staff had the right experience.

Is the service effective?

Requires Improvement

The service was not always effective.

Decisions made on behalf of people who lacked capacity were not made in accordance with the Mental Capacity Act 2005.

People were cared for by staff who were aware of their roles and responsibilities, but were not always suitably trained in aspects of their role.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always communicated with when staff were providing support to them.

Staff were knowledgeable about the people they were supporting.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not routinely provide staff with guidance

how to support a person.

People were not always supported to undertake activities of their choice.

People were able to identify someone they could speak with if they had any concerns. There were procedures for making compliments and complaints about the service.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

People could not be certain any serious occurrences or incidents were reported to the Care Quality Commission. Where required the provider failed to notify CQC of reportable events.

Quality assurance processes were not effective and did not highlight all areas of required improvement.

Seeleys House Short Breaks Centre

Detailed findings

Background to this inspection

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

The inspection took place on the 27 and 28 June 2017 and was unannounced; this meant that the staff and the provider did not know we were visiting. The inspection was carried out by two inspectors, on day one the inspectors were joined by 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.

Before the inspection the provider was not asked to complete a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We gave the provider as opportunity to share with us about any planned changes. We reviewed notifications and any other information we had received. A notification is information about important events which the service is required to send us by law.

We spoke with three people living at the home who were receiving care and support. We made 28 telephone calls to relatives and spoke with 17 family members. We spoke with the manager, deputy manager, Interim operations manager and interim director. We met and spoke with six care staff. We reviewed four staff recruitment files, 10 care plans and four medicine records within the service and cross referenced practice against the provider's own policies and procedures. We asked the provider to send further documents after the inspection. The provider sent documents to us which we used as additional evidence.

We 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 also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and social care professionals responsible for people who used the service.

Requires Improvement

Is the service safe?

Our findings

People were not routinely and consistently protected from avoidable harm. There were omissions in adequate assessment of risk. People's care plans included a general risk assessment document. This outlined some of the risks to the person and staff. However all areas of risk were not identified and managed such as risks around the use of bed rails, choking, pressure sores and epilepsy. In one person's file we saw an undated note which indicated the person had a pressure sore. There was no risk assessment to indicate how this was to be managed. We found a Waterlow (pressure risk assessment tool) risk assessment had been completed by the district nurse. This was in the district nurses (DN) file in the person's bedroom but not known to staff. The person was deemed a high risk on the Waterlow assessment completed by the DN during this admission.

Where risks were identified they lacked detail as to the control measures in place to reduce and manage the risk. A risk assessment for a person who was diabetic made reference to hypoglycaemic and hyperglycaemic comas but did not provide the detail around how staff would recognise those. Staff spoken with were not trained in diabetes and were unable to tell us how they would know if a person was experiencing hypoglycaemic or hyperglycaemic symptoms.

One person had a PEG (Percutaneous Endoscopic Gastrostomy) feed in place. A feeding schedule was in place which outlined how the feed was to be given. It indicated if the person was "Sick" staff were to call the emergency services as the person had a previous surgical procedure. However details were not provided as what that surgical procedure and none of the staff spoken to were able to tell us anything about the medical procedure, however they told us they would follow the care plan to call the emergency services.

People who had been identified as high risk of chocking had risk assessments in place however; they did not provide adequate guidance for staff on how to mitigate the risk. For instance, one person's risk assessment stated "food to be cut up into small pieces and should be served moist." This did not provide sufficient detail for staff as one staff member's perception of small could be different from another. We were concerned that people at risk of choking were not protected. One person who had had a previous choking episode did not have an up to date care plan in place and had gone on to be hospitalised from Seeleys House Short Break Centre following a choking incident. Following the inspection we contacted the provider for an urgent action plan to improve this area of practice. The provider had informed us that people with a choking risk would not be admitted to the service until their choking risk assessments and guidance had been updated.

We found the service did not ensure people were protected from risk associated with fire. Since the new provider took over the service planned refurbishment was undertaken. The works had been carried out by a contractor. However the Intumescent seals on the fires doors had been painted over. Intumescent seals are designed to expand under heat, and fill the gaps between the door leaf and frame, thereby preventing the passage of smoke and fire to other parts of the building. This meant people could have been exposed to an avoidable hazard in the event of a fire. However at the time of the inspection we were informed the doors were due to be replaced and we have since received confirmation from the provider that this had been completed. We found no regular checks were undertaken on soft furnishing to detect any failings in fire

protection. Fire alarms were tested but not consistently on a weekly basis.

A fire risk assessment dated 14 August 2016 was in place but this had been completed by the previous provider. A number of actions were still outstanding. We asked the provider and manager about fire safety. They told us the 2016 fire risk assessment was an exact copy of the 2015 fire risk assessment and no review of fire risk had happened. The provider had asked Buckinghamshire Fire and Rescue (BFR) team to attend the service and make an assessment of fire safety. The BFR had visited the service and had issued a notification of fire safety deficiencies. The notice outlined what improvements were required to improve fire safety and a timescale had been placed for the remedial action to be undertaken. We spoke with the provider about this and they have acknowledged the notice and are actively working on making immediate improvements. The provider has agreed to keep CQC updated with progress made to improve fire safety. The likelihood of harm during a fire was reduced as each person had a personal emergency evacuation plan (PEEP) which was readily available for staff in a grab bag.

Systems were not in place to manage accidents and incidents. People's care plan included body charts which showed staff had noted bruises, cuts or a sore on the person's body. There was no evidence any action had been taken or management plans put in place in response to their findings to prevent deterioration or reoccurrence. Accident and incidents were not routinely reviewed by a manager to ensure all events were properly reviewed and investigated and the required safeguarding alerts made.

People who required support to take and manage their prescribed medicines had support from staff who had received training. The provider had introduced a new medicine policy and staff were due to receive training. The policy provided guidance in relation to respite admissions, covert medicines, as required medicines as well as pictorial guidance on how to administer ear and eye drops. However, the policy did not make reference to the use of thickeners in fluids. Following the inspection we received confirmation from the provider they had made plans for this to be rectified.

One person required thickeners in their fluids. The persons care plan made reference to a thickener in their fluids but did not provide any guidance around the consistency. Staff told us they would follow the instructions on the packet but three staff spoken with gave us differing views of how the person's thickener should be prepared. This put the person at risk of choking. Staff should have access to comprehensive information about amount of thickener required and this was not in place.

We looked at a number of MARs; there was inconsistent practice on how these were completed. This meant some forms were easier to read and follow than others. Prior to a person being admitted the service sought up to date information on any changes in prescribed medicine from the person's GP. However we found this was not routinely returned from the GP prior to the person being admitted. For instance one person had been prescribed antibiotics and had received three doses prior to authorisation being received from the GP. This meant there was a potential for mistakes to occur and authorisation had not been sought from this person's GP.

Some people were prescribed 'as required' (PRN) medicines. It is widely accepted good practice for providers to ensure staff have additional information available to them for PRN medicines. This includes why it is needed and when to give the medicine. We found inconsistent practice around the management of PRN medicine. For people who required epilepsy recovery medicine, there were detailed protocols in place, as to when the medicine was needed. However, when people were prescribed analgesic medicine, people's records did not routinely and consistently contain additional information on when and why it should be given. This meant there was a potential for people to receive too much or too little of their medicine to manage their health condition. We discussed this with the provider. They told us they were confident the

new systems being introduced would reduce any risks around medicine management.

These were all breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and safety checks were not consistently and routinely completed. Weekly hoist checks had not been carried out since 2 June 2017. Two faults had been recorded on the 19 May 2017. We asked staff if the fault had been repaired and they did not know. We asked the manager and they were unaware the hoist was not fully working or if it had been reported. We checked the two hoists in question and found the hoist were unable to be lowered using the remote control. Both required a manual override. The cord for the manual override was at such a height it would require staff to stretch to reach it. No risk assessment had been put in place for this. We made the provider aware of this on day one of the inspection and the fault had not been repaired by the time we left on day two. No Legionella risk assessment was on site to review and no water sampling had been undertaken. Water temperatures recorded highlighted there was a growth risk of Legionella. However no remedial action had been taken. The provider has since commissioned urgent testing. Water temperatures taken in two bedrooms were recorded as high as 52.6 Celsius. This exceeded the safe upper temperature recommended by the Health and Safety Executive of 44 degrees Celsius. This presented a risk of scolding.

These were breaches of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not routinely and consistently protected from the risk of abuse. The provider had a safeguarding policy in place. Staff told us they had been trained in safeguarding and told us they would report poor practice. However senior staff were unclear what needed reporting and subsequently told us they rang the local authority safeguarding team for advice but failed to record those discussions. During the inspection we saw incidents recorded in the staff meeting minutes were referred to as safeguarding incidents. However there were no subsequent referrals made to the Local Authority safeguarding team. Staff gave us different examples as to what they thought these incidences related to. After the inspection the manager provided us with details of the incidences which contradicted what the staff told us. They advised the incidences were not considered to meet the threshold for safeguarding but there was no record on the files viewed at the inspection that a discussion had taken place with the Local Authority safeguarding team to confirm this.

We saw an incident had been reported by a visiting professional to the Local Authority Safeguarding team. This was because one staff member carried out personal care when the person's care plan stated the person required two staff. We asked staff why they had not considered the practice was unsafe. Staff said it was because the person had always had one to one for personal care. However when the care plan was updated it had been changed to two staff for personal care but staff were not aware of the change.

These were breaches of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about staffing levels. On day one of our inspection the service had an unexpected admission. They had planned for seven people to be cared for. The staffing had been arranged to ensure the seven people could be cared for safely. On discovering an eighth person was due to stay overnight the management arranged for additional cover. On the second day of our inspection we noted seven people were due to stay overnight. The service had arranged for four staff to be on duty. Four of the seven people were dependent on the use of a wheelchair for their mobility needs and three of them required

two members of staff to help them to move position. Two staff members told us they did not think there were enough staff on duty. One member of staff told us "Looks like I am superwomen tonight." They thought they had been given too many people to look after with. We asked the provider how staffing levels were arranged. We were informed that consideration was given to the level of need of each person. For example, whether people needed support with personal care, if people were dependant on a wheelchair for mobility and any other special needs, for instance monitoring of fluid intake. The provider confirmed sufficient staff were on duty for that shift; however there was no evidence this was recorded or reviewed. The provider informed us that a decision had been made to increase staffing levels by one person each shift to ensure people were provided with safe care.

People were supported by staff with the appropriate experience and character to work with people. The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). We spoke with the manager about ensuring they held copies of all the pre-employment checks completed on file.

We received mixed feedback from family members about people's safety. Positive comments from relatives with spoke with were "I am sure she is safe there"; "Since Seeleys House has been updated I do notice that it feels cleaner and tidier" and "[Name] is on medicine and I am regularly given an updated doctors certificate as and when they request it, this really gives me confidence that the service is making sure that the medical requirements are met." Relatives who were less pleased with the service told us "It's interesting that my son has not had to go to hospital from home, and obviously he has gone three times from Seeleys House, I am appalled at this service. They seem to have let our family who need the respite and my son down" and "If there was an alternative to sending him to Seeley House I would send him elsewhere." We fed this feedback to the provider.

Requires Improvement

Is the service effective?

Our findings

People were not routinely and consistently supported to have their human right protected. The service did not always support people with decision making in line with 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found inconsistent practice around supporting people with decision making. Some people had been referred to the local authority. Social care staff had completed Mental Capacity Assessments and had followed the best interest process. For instance, one person had been assessed as not able to make informed decisions about their care and welfare. A best interest decision had been made about personal care, review of needs, finance, medicine, restrictions around care and behaviour. However in other examples no consideration had been made to people's decision making. For instance the use of bed rails was not considered.

People can only be deprived of their liberty so that they can 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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

A number of people's movement was restricted either by wheelchair seat belts or bed rails. These are forms of restraint and may require a DoLS to be in place. The service did not consider this to be restraint. One person had an authorised DoLS in place which made no reference to the use of bedrails. Another person who used bed rails and seatbelt had not been referred to the local authority (Supervisory Body) for a DoLS assessment. Where a DoLS assessment is not deemed necessary and the person lacks capacity to make a decision about restrictive practice a best interest process should be followed.

One person was prescribed a vitamin tablet. The MARs stated "One tablet daily, to be crushed in food." The person was unaware the medicine was being given. This is known as administering medicine covertly. An application had been made to the local authority for this person and the provider was awaiting confirmation of the DoLS. However the application had not included this person's covert medicine and there was no evidence of a best interest process The service had not ensured best interest processes was routinely and consistently applied.

The service did not follow the code of practice for the MCA as they routinely sought consent from third parties and family members who did not have the legal authority to act on the person's behalf. Where family members or third parties do not have legal authority the service should follow the best interest process to record decision making. Although staff had received training in the MCA, they lacked awareness and understanding on how to apply it. For instance, one staff member told us "We haven't done a MCA as his

mother has refused for it to be completed." In another person's file we noted a relative had given permission for an anti-histamine to be administered. The relative did not have legal authority to give consent for this decision.

These were all breaches of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a corporate induction policy and training for new staff. However we found no evidence this process had been followed for new staff. Staff we spoke with however told us they had been supported since commencing employment. One member of staff told us "I feel fully supported." Staff worked alongside more experienced workers until they had received all the required training and support to work alone.

Staff undertook training which the provider had deemed mandatory, however specialist training had not always been offered to staff. Staff we spoke with had not received training in diabetes, autism awareness, key working, risk assessments and care planning, despite supporting people with those conditions and being involved in those roles. We raised this with the provider; they told us they would review training requirements. After the inspection the provider confirmed what training they had arranged in risk assessment and mental capacity.

People's care plans included guidance on the support they required with their meals. Some care plans provided guidance on the support required in relation to special diets, crockery, cutlery and level of staff supervision. Others lacked specific detail around how the support was to be delivered and stated "Support to be provided with meal". Relatives we spoke with gave us positive feedback about meals. Comments included "My son is very hard to feed and they spend a lot of time making sure that he is fed properly" and "[name of person] would tell me if she was unhappy there and she certainly does not like to be picked up (collected) until after the Sunday Roast."

People had food and fluid charts on their files. The care plans did not always indicate why fluid charts were being maintained or the required fluid intake. Fluid and food charts were not routinely completed or provided an accurate record of fluid taken by people.

The service had a cook and chef who worked opposite each other to ensure there was always one of them on duty. The cook took responsibility for menu planning. Two meal options were provided at the evening meal which gave people a choice. There was a list maintained of special diets such as soft, puree, halal or diabetic options. People were happy with the meals provided. They described them as "Good, very nice, tasty."

The service referred people to external healthcare professionals when required, for instance, one person was referred to the GP following deterioration in a wound on their skin. The provider had engaged with a local GP practice to provide emergency medical support for people who stayed at the home. A working protocol was being written and finalised at the time of our inspection. The provider was confident people's medical needs would be met.

Requires Improvement

Is the service caring?

Our findings

People we spoke with gave us positive feedback about the staff. They told us they were happy with the care provided. They described staff as "Very nice, helpful, kind and caring. Other comments included "I like it here, at Seeleys" and "The staff are nice, they are."

Relatives told us they recognised the staff had worked hard to make improvements to the service. Comments included "I am very appreciative of the staff especially after all the difficulties they went through with management, their commitment to their work and especially the users this was really appreciated by the parents," "They are very open and honest and the staff that I deal with are very caring and attentive" and "I am happy with the Seeleys Respite Centre , there has been a marked improvement since the changeover of staff, my daughter recently went for 12 nights and when she came home seemed very well cared for, her hair was washed and I was happy to see no clothes missing."

We observed positive and negative interactions. Some staff were gentle and engaging with people. They provided good eye contact, smiled and used appropriate touch when reassuring people. They treated people with dignity and respect whilst also having fun and laughter with them.

Other staff were less engaging. They sat on the settee next to people but did not interact with them. They provided people with drinks without asking people what they would like and handed them a drink without any engagement. Another staff member was sat in the sitting room checking people's belongings in with minimal acknowledgement of the people coming in to the room.

People's privacy was promoted. People were taken to their bedrooms to be supported with personal care. This was carried out in private.

People's care plans made reference to their cultural needs but then did not provide detail or guidance to staff around how these were to be supported.

People were supported by staff who knew their likes and dislikes. One person told us how [name of staff] had been their key worker since they had attended the home. We observed interaction between the person and the member of staff; it was clear the staff member knew the person well and had developed a good relationship with them.

Peoples care plans contained guidance around the support required with communication. These indicated if people could verbalise their needs or not. Where people were unable to communicate verbally there was reference to the use of Makaton and objects of reference such as showing people pictures or an item, for example, food or drink. One person used their iPad to communicate. However, staff were not trained in Makaton and the detail around the objects of reference to use with individuals was not outlined. During the inspection we saw one staff member use signing with one individual. However, staff did not consistently use signing when communicating with the individual and pictures or iPad was not routinely used for people who required it.

People were not routinely involved in decisions about their care. Throughout the course of our inspection staff would refer to people's relatives making decisions, rather than involving the person.

Some people were independent with personal care and staff encouraged this. One person who only required prompting told us "The staff help me if needed, especially at times of the month." We observed staff handing one person freshly laundered clothes to put away. The person told us they liked to stay at the home.

Requires Improvement

Is the service responsive?

Our findings

People did not routinely and consistently receive person centred care. The provider had an admission protocol for people being admitted to the service for the first time. This indicated that a pre admission assessment would take place. The service had not admitted any new people to the service since being registered and no new admissions were being considered at that time.

The provider had introduced a pre stay checklist form to be completed for people already assessed and receiving respite care. This was to establish if any change in needs since the previous respite admission. However there was no guidance around how and when the information should be obtained and we found only one completed pre stay checklist in the care plan files viewed.

Staff involved in arranging admissions told us they had conversations with families prior to their family member coming in to establish any changes in the person's needs. They also said they liaised with the GP regarding current medicines but there was often a delay in getting that information through from the GP prior to the person coming into the service. However a record was not maintained to show these conversations had occurred and they did not routinely complete the pre stay check list.

People had care plans in place. The care plans viewed included an essential information sheet and outlined information about the person such as any physical or mental diagnosis, likes dislikes and expected outcomes. The care plans provided an assessment of the person's needs but lacked detail and guidance around how the support was to be delivered. For example care plans outlined how staff were to support with personal care, meals, stoma and sheath care but did not provide specific guidance and instructions for staff to follow. Some staff knew people well and knew the support they required. Other staff did not know people and said they relied on other staff to guide them. Care plans showed no evidence of people's involvement in them and people were not aware they existed. Aspects of the care plans referred to the person as "X" and a similar completed template was used for people which was not person centred or relevant to them. Some care plans made reference to epilepsy protocols but there was no epilepsy protocol available in care plans or in the epilepsy protocol folder.

These were breaches of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People did not have access to regular activities. Care plans did not routinely and consistently make reference to their interests or hobbies. No activity programmes were in place to indicate activities were made available to people. Staff told they sometimes took people out to the cinema but this was recorded in individual daily records. An overview of what community activities had been provided was not available. On day two of the inspection everyone watched a film on the TV. No other activities were seen to be offered or provided. We received mixed feedback from relatives about access to activities. Positive comments included "When she returned I got a detailed report on her activities" and "I was thrilled that recently my son was taken to the cinema that has never happened before, I am encouraged by this and feel he would benefit from more outings if possible." Other relatives told us they felt there was no evidence of activities and would

rather know that their family member was being supported to engage in meaningful and fun activities.

People's care plans included an emergency grab sheet. These outlined people's personal details and medical conditions. This was to be used in the event of a person requiring admission to hospital.

People told us they would talk to staff or the manager if they had any concerns. Staff told us they would report any concerns raised by people or their families to the senior in charge or manager. The organisation had a complaints leaflet which provided details on who to contact if people or their relatives were unhappy with any aspect of care. A system was in place to log complaints. No complaints were recorded since the service was registered on the 5 May 2017.

Inadequate

Is the service well-led?

Our findings

People were supported by a service that was not well-led. There was no registered manager in post. At the time of our inspection a manager was in post. They had been seconded from another service to cover management at Seeleys House Short Breaks Centre until a permanent manager was employed. The provider told us a new manager had been appointed and was due to commence employment in due course. The manager had applied to CQC to be registered and at the time of the inspection the application was being processed.

The provider had an improvement action plan in place. It detailed areas where improvements were required. However we found some areas which had been marked as completed required further work to ensure new ways of working were embedded. We found there wasn't effective reporting system for incidents and accidents. We noted two issues had been raised in a team meeting held on 1 June 2017, relating to medication errors people; however we found no record of this in either daily records or incident log. There was a lack of effective systems to monitor incidents and accidents. Staff were not always aware of how to record events, some medication errors were recorded on incident forms, some on medication error forms and others reported as safeguarding. The improvement plan had indicated that all staff were aware of how to report incidents and accidents and the action had been marked as completed. Incidents and accidents were not analysed or investigated to prevent a future event. This created a risk to people. The provider had failed to recognise this in the action plan.

Quality assurances processes were not effective. A health and safety audit conducted on 19 May 2017, advised there was a fire risk assessment in place which had been reviewed in the past twelve months. However the audit failed to pick up there were outstanding actions and that it was not owned by the current provider. There was no current fire risk assessment in place. The provider had subsequently asked for a reputable company to undertake a risk assessment.

The provider had requested a health and safety audit to be undertaken by their internal health and safety team. It was carried on 30 May 2017, the service was rated 'unacceptable' and a number of actions required 'immediate attention required to reduce risk'. One of the actions highlighted was to replace a carpet in one of the bedrooms. The carpet was worn and laid loosely thus creating a trip hazard. On both days of the inspection we noted the carpet had not been replaced. The audit had failed to pick up that no Legionella risk assessment was on site and no water sampling had taken place. Following the inspection we received a health and safety tracker document from the provider. This detailed 188 actions which required attention, were pending or had been completed. We noted the carpet had been reported to the facilities team on 29 June 2017, nearly one month after the provider was asked to replace it. We checked if the room had been used and it had been. We acknowledge some actions had been undertaken in a timely manner; however this was not consistently completed to reduce potential harm to people.

There was a lack of ownership for following up on outstanding actions. For instance, a routine maintenance check on a shower bed had identified the mattress needed replacing as the cover had a split which could have caused cross contamination. The advice was that the mattress was needed to be replaced 'ASAP'. We

asked the manager if this had been replaced and they were unable to confirm this, no records were held about monitoring repairs. We checked the mattress and it had a split in it. We have asked the manager to take immediate action to address this.

Records required for regulation were not suitably maintained. Records were not stored in line with The Data Protection Act 1988 as we found documents containing personal information in another person's file. Some people's daily records were not dated and did not always include their name. Records relating to changes in people's condition were not always complete. For instance, the service used body maps to record any bruising or marks, although dates were added to the body chart, no action or follow up had been recorded which was easily accessible to staff. We did find some reference to some bruising in the communication book, however this was difficult to find amongst other information about staff sickness and staffing levels. Records relating to PRN medicine were not always present, which could have led to people not receiving their medicine as prescribed.

Team meeting minutes did not include the full details of discussions held As the minutes were not written up in full. Which meant staff not present at the meeting would not understand what had been discussed. Issues were discussed at team meetings which required action These were not followed up and no-one had been identified to take responsibility for the action.

There was a lack of effective communication among staff. Some staff had good knowledge of what work was required and any progress made. However there was a lack of oversight and clear level of responsibility. Some staff had been delegated tasks which they had not been supported to be fully trained in. For example, staff who were not a keyworker for a person were not always aware of the details written in care plans. There was no system in place to ensure all staff were aware of each person's individual needs.

These were breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt the service had improved since the previous inspection. They felt better supported and had a better understanding of what was expected from them. They told us they found the manager to be accessible and approachable. Other staff however, told us the manager did not promote good team work.

Staff were calm and the home had a relaxed atmosphere. Staff were passionate about providing a quality service. The service had been supported by external social care professionals. Some staff told us they felt disempowered and removed from the care planning process as a result. We have provided feedback to the provider about this.

There is a legal requirement for providers to be open and transparent. We call this duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation. At the time of the inspection the provider did not have a policy for staff to follow in the event of the duty of candour threshold being met. Following our inspection, the provider has sent us guidance for staff to follow. We checked if there had been any notifiable events. There had been one incident that met the threshold for duty of candour. We did not find any evidence that the duty of candour had been used accordingly. Staff also confirmed that no apology was offered to the person or their legal representative.

These were breaches of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when a DoLS application has been assessed and a decision made whether to authorise the deprivation or not. We were aware that at least three DoLS applications and decisions made. However CQC did not receive any notification from the provider.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Relatives we spoke with recognised improvements had been made both in the decoration of the building and the service provided to their family members. Relatives told us "They have fixed lots of things in the building and it is much nicer now"; "I have never had a problem with Seeleys House and my stepdaughter goes there every month" and "The facility is much improved, it is better than before and they have mended their ways."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service did not always notify CQC of events it was legally obliged to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not fully mitigate risks posed to people, as risk assessments were not robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have systems in place to effectively deal with safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service did not ensure all equipment used was fit for purpose. Systems were not in place to report and monitor repairs required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not undertake the required

actions when the Duty of Candour threshold was met.

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 11 HSCA RA Regulations 2014 Need for consent The service did not ensure it complied with the Mental Capacity Act.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have adequate and robust quality monitoring systems in place to drive improvement.

The enforcement action we took:

We issued a warning notice.