Prime Life Limited

Seacroft Court Nursing Home

Inspection report

Seacroft Esplanade
Skegness
Lincolnshire
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected Seacroft Court on 5 January 2016. This was an unannounced inspection. The service provides care and support for up to 50 people. When we undertook our inspection there were 44 people living at the home.

People living at the home were mainly older people. Some people required more assistance either because of physical illnesses or because they were experiencing memory loss. The home also provides end of life care.

There was 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.

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

Summary of findings

necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of our inspection there was no one subject to such an authorisation.

There were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

People's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. 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.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. And meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements.

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 safe.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Record keeping and stock control of medicines was good.

Good

Is the service effective?
The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Good

Is the service caring?
The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Good

Is the service responsive?
The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated in a confidential manner.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Good

Is the service well-led?
The service was well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance.

Good

Summary of findings

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

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 5 January 2016 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor in dementia and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke with other health care professionals during our visit.

During our inspection, we spoke with four people who lived at the service, five relatives, five members of the care staff, the clinical lead, a trained nurse, a cook, a housekeeper, the registered manager and two area managers. We also observed how care and support was provided to people.

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 looked at eight people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and questionnaires which had been sent to people who used the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and did not have any concerns about the staff caring for them. One person said, "I always feel safe in the hoist. I put my complete trust in them here." Another person said, "I feel very safe and secure here."

The home had key pad entry and exit locks on all outside doors, which people knew the code for or were given access to when visiting. People could move about freely in the rest of the home, but there was very little directional signage. People and relatives told us this was sometimes confusing for those with memory loss as others sometimes could enter their rooms unannounced. Staff told us there was the facility for people to lock their own doors. One person said, "I feel safe because I can lock my door. If I couldn't I wouldn't feel safe because any resident can walk into my bedroom." A relative told us, "I feel she's fine but I don't' feel her belongings are safe."

Staff told us they tried to observe people with memory loss and who tended to lose their way in the building. We saw all staff trying to divert people away from rooms they should not enter unless invited during the course of the visit. The registered manager told us this was a sometimes difficult task for staff and was working with people and relatives all the time so they understood people's needs and problems. This was seen in minutes of meetings for September 2015.

Staff were aware of the signs of abuse and the action they should take if they identified a concern.They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right action to safeguard people. Notices were on display in staff areas informing staff how to make a safeguarding referral. Staff had received training in how to maintain the safety of people.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through meetings when actions needed to be revised.

Individual risk assessments had been completed for people to assess their risk of developing pressure ulcers, falls, moving and handling and nutritional risk. These had been reviewed at least monthly and more frequently when people's needs had changed. For example where people were having a series of falls. This had taken into consideration accident analysis of each person and other factors such as a deteriorating mental capacity. Support had been changed for each person according to their individual needs.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and how they required to be moved. For example being able to walk unaided. A plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency.

Moving and handling equipment was available in line with people's individual requirements. We saw these had been maintained on a regular basis and all passed as safe to use. We observed that when people were being transferred to dining areas for meals staff used safe techniques to move them. Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers. A system was in place to ensure they were correctly inflated and safe to use.

People told us their needs were being met. However, people told us that at times the staffing levels could be better, but it had recently improved. One person said, "I think they could do with another pair of hands. It has got better lately." Another person said, "its fine here. I get everything done."

Staff told us there were adequate staff on duty to meet people's needs. One member of staff said, "its better now. Ok it's hard work but the client to staff ratio is better." Another staff member said, "We now have adequate staffing. We can feed back to the manager and we get staff to do escort duty." They said the senior staff always tried their hardest to ensure sufficient staff were on duty to cover short term absenteeism such as sickness. Staff told us they all worked as a team in all departments.

Good

Is the service safe?

The registered manager showed us how they had calculated the numbers of staff required, which depended on people's needs and daily requirements. The last calculations were completed in December 2015. The records showed this was completed at least monthly but more often if numbers of people using the service or people's needs changed.

We looked at two personal files of staff that had been recently recruited. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. The registered manager checked the details of all the nurses who were on the Nursing and Midwifery Council (NMC) register to ensure they were safe to practice and held a valid registration.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. This had been explained by GPs', hospital staff and staff within the home. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked area. There was good stock control. Temperatures were recorded to ensure the medicines were stored in suitable conditions. This would ensure the stored medicines were safe to use and were stored appropriately and safely. Records about people's medicines were accurately completed. One person was able to take their own medicines. Staff had assessed their capability, which was reviewed monthly.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Good

Is the service effective?

Our findings

Pre-admission assessments had been completed for people to assess their care and support needs. Each care record had a personal profile to provide key information about them and contact details of their relatives. People's preferences on a number of topics had been recorded; such as what time they would like to go to bed.

Two staff members told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling, administration of medicines and bathing people. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. One staff member told us how their induction programme had been adapted to suit their individual needs. They said, "I had support throughout my induction."

Staff said they had completed training in topics such as basic food hygiene, first aid and manual handling. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Some staff had completed training in particular topics such as palliative care and care plan writing. This ensured the staff had the relevant training to meet people's specific needs at this time.

Staff told us they could express their views during supervision and felt their opinions were valued. This ensured they had a voice in their workplace and could comment on the running of the home. We saw the supervision planner for 2015. This gave the dates of when supervision and appraisal sessions had taken place. The records included training which had taken place and planned. Staff confirmed these had occurred.

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There was no one currently in the home that had an authorisation order in place.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted.

An action plan was in place to record when applications had been submitted where a person's liberty had been assessed. When a person had appointed a relative to have power of attorney over their care, welfare and financial matters a copy was in the person's care plan. This ensured staff were aware of who to contact about the person's needs.

People told us that they enjoyed their meals. One person said, "its good healthy food." There were no menus on display on the day of our visit. However, the cook showed us the folders which were usually on each table and which contained menus for other days. These had unfortunately not been placed on the tables that day. All tables had been set out with cutlery, condiments and jugs of juice and glasses, except in the dining room used by those with memory loss. The tables had not been set, so people were confused as to why they were being asked to sit at a table to eat.

People could sit where they wanted to. Some choose to remain in armchairs or sofas. The lunch time meal we observed contained freshly prepared vegetables and two main course dishes. Some people tried their first choice, but didn't like it, so this was changed by staff immediately. Some people needed assistance to eat. This was done in an appropriate way, with staff concentrating on each person, giving encouragement and maintaining eye contact. Hot and cold drinks were served with biscuits throughout the day and the staff member knew what people liked.

During the course of the meal observation in the main dining room all care staff attended to an emergency situation in another part of the building. Although this did not last long the dining room was without staff to observe people's safety. An argument took place between people at

Good

Is the service effective?

a table and staff from the kitchen defused the situation. The registered manager told us the protocol was for one member of staff to stay to observe in all areas and this was to be addressed with staff on duty that day.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their weight and when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans. The kitchen also kept copies of people's likes and dislikes.

Kitchen staff had one to one meetings with people throughout the year to discuss their needs and menu planning. All meals had been discussed and each person's specific comments recorded. Where people required special cutlery to eat and had stated the portion sizes they liked we observed this had been adhered to during a meal time observation. Staff told us they had tried various themed meal events throughout the year which included an around the world theme, Italian and Chinese days. The internal newsletter gave details of a country and western theme day where different barbeque food had been on offer and another with a seaside theme. This included seaside fare such as cockles and mussels and ice-cream. People told us they remembered those days and had enjoyed them. Pictures in the newsletter showed people enjoying the food on those occasions.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to complete some hand and arm exercises to help their stiffness. We heard staff speaking with relatives, after obtaining people's permission, about hospital visits and GP appointments. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

People told us staff tried to obtain the advice of other health and social care professionals when required. People described the "footman" coming to see them on a monthly basis and the optician visiting. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people required special eye screening for a medical condition and when a person's life was coming to a close.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were confident staff would give them good care and liked living there. Staff were described as caring and kind. One person said, "I have a good laugh with them. " Another person said, "They would do anything for you. Nothing is too much trouble."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "They know who I am. I feel like this is my home." Every person we spoke with told us staff treated them with dignity and respected their privacy. A relative told us, "He looks very well cared for. He's comfortable. When we were looking for homes and came here one of the things that made us like it was the caring atmosphere. You felt it as soon as you walked in. We made the right choice."

All the staff approached people in a kindly, non-patronising manner. Staff spoke to everyone in a caring and calm tone of voice and manner. They made eye contact and got to the same level as each person. There was evidence that some members of staff had developed a rapport and relationship with some people. They shared on going jokes.

Staff attended to people who were distressed in a calm manner and offered them a more private space to discuss their needs. For example, one person was distressed about when family would be visiting and were reassured constantly by staff about the time until the relative appeared. Staff were observed knocking on doors before entering people's bedrooms and waited for an answer before opening the door.

One person described how when a hoist was used to bring someone into a communal area staff always covered their legs and the bottom half of their body. We observed this happen and the person's dignity had been preserved. People told us if they did not staff of a different sex to attend to them this had been respected.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, where they wished to sit in different rooms and the right to refuse a bath or shower.

Staff responded when people said they had physical pain or discomfort. When someone said they felt unwell, staff gently asked questions and the person was taken to one side. When the emergency call bell was sounded we saw staff respond to the person's need. As soon as possible the minimum amount of staff stayed with the person, not to frighten and worry them.

Relatives we spoke with said they were able to visit their family member when they wanted. Some visited every day and spent a long time with their family member. They said there was no restriction on the times they could visit the home. One person said, "I can have visitors any time." Another relative said, "My [named relative] says he likes the staff at this lovely hotel."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display.

Good

Is the service responsive?

Our findings

The people we spoke with told us staff responded to their needs as quickly as they could. One person said, “They discuss everything with me.” Another person said, “When I need help I get it and they are very good about calling in the doctor.”

People told us staff had talked with them about their specific needs. This was in reviews about their care, meetings and questionnaires. They told us they were aware staff kept notes about them and relatives informed us they also knew this. They told us they were involved in the care plan process. This was confirmed in the care notes we reviewed. Staff knew the people they were caring for and supporting. They told us about people’s likes and dislikes. For example, which people liked to use the smoking room and who required attention to pressure ulcers. This was confirmed in the care plans.

Relatives told us they were involved in their family member’s care for those who could not make decisions for themselves. One relative said, “They always tell me how she is and how she has been. They always ask my opinion.” Another relative said, “Each time we come in we’re always able to ask questions and they give us information.”

Staff also received a verbal handover of each person’s needs each shift change so they could continue to monitor people’s care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. Each staff member had a written handover sheet which gave details of each person and treatment which had to occur daily. This included checking on the completion of food and fluid charts, any appointments people were required to attend and ensuring anyone who had asked for a bath or shower received it.

Care records contained a personal profile providing information about the person. There were a range of care plans to indicate people’s care and support requirements and each contained person centred information. These had improved since our last visit but some varied in their content, but gave an over view of each person’s needs. However, in two of the care plans staff had not explained the people’s needs in a comprehensive way. For example including comments about physical health when the main care plan was about dementia needs. In another care plan about a person’s physical health, this also contained details of the person’s mental capacity. The provider has a robust care planning structure for staff to follow, which on two care plans seen had not been followed through.

Staff had recorded when they had accessed the advice and support from other health care professionals. For example, when someone had increased anxiety. Staff had pursued the help of appropriate health care staff to ensure the person could be assessed and treatment commenced if required. In another care plan a person had an illness where treatment was required each day. Staff had asked and received training to ensure they could continue the treatment when community nurses were not available.

Health and social care professionals we spoke with before and during the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions. They told us staff were willing to engage with them to ensure people’s health and wellbeing was being maintained. To ensure staff were kept up to date with the health and well-being needs of people link staff roles had been developed. These included infection control, continence, diabetes and nutrition. Staff told us they enjoyed expanding their own knowledge base, passing this on to other staff and liaising with other health and social care professionals. Folders were in place with up to date information for staff to access. Lessons learnt and passed on included how to ensure bathrooms and toilets were fit to use and a system put in place to maintain cleanliness.

People told us there was an opportunity to join in group events but staff would respect their wishes if they wanted to stay in their bedrooms. We asked people about day trips out and one person told us they go for a ride in the country. Although there was a daily chart of activities displayed in the reception area for group events there was no programme aimed at people’s individual needs. Of the care plans we reviewed only one had specific mention of an interest of that person. All the other social inclusion care plans were generic and consisted of comments such as “mixes with others” and “spends time in their room.” No one stated to us that they or their family member would like to participate in individual hobbies and interests, but neither was this recorded in people’s care plans. Staff

Good

Is the service responsive?

would need to be aware this may be a question to ask as they got to know each person. Some relatives had started their own group activities with the help of staff such as bingo and sing-a-longs.

Staff interacted with people in their bedrooms and were observed sitting and talking to people. Some people who liked to remain in their rooms each day had visitors. One person told us they did not like to mix and enjoyed their own company. There was no evidence of dementia friendly activities being planned, but we did observe staff speaking with people about their lives and commencing a singing session, which people appeared to enjoy. In one sitting room, where people with memory loss were sitting there was no wall decoration such as pictures and little decoration to stimulate their mind. The registered manager told us this was an area they were currently looking at to improve and would be included on the maintenance programme.

A newsletter was produced monthly. This included information from the registered manager about the running of the home. It also reminded people of forth coming events, successful visits out to such as the Parrot Zoo, poems and birthday celebrations. This was on display and staff told us they could produce it in other formats such as large print and other languages.

People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People knew all the staff names and told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display. The complaints log detailed any concern which had been raised since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the case had been passed to staff at their meetings in 2015. The registered manager completed a monthly audit of complaints to send to the head office for information purposes.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "If I have a problem I put it in [named staff member] hands and I don't have any more. She listens to me and sorts it out." Another person said, "She is brilliant, always there for you. For anything you want. She goes out of her way to make things right for you." A relative told us, "It's been very open from the first visit. We came out of the blue and we saw [named two staff]. They showed us around and were very welcoming."

People who lived at the home and relatives completed questionnaires about the quality of the service being received. Some people told us they had recently completed questionnaires. People told us they felt their comments were listened to and acted upon. For example, when people wanted a bigger variety of fresh vegetables, they appeared on the next week's menu.

In one of the corridors the results of the last questionnaire were displayed. This was in word and picture format. The results were positive. Comments included, "staff are so friendly" and "it's a nice care home." Any actions were also displayed on how the provider would follow through concerns raised; such as themed days to continue.

People and relatives told us they attended regular meetings. The next one was displayed on the notice board. Meetings had been held with relatives in June 2015 and September 2015. These discussed topics such as activities and end of life care. Relatives told us they felt involved in the home. One relative said, "I like this place. From my point of view it's free and easy with a relaxed atmosphere."

Staff told us they worked well as a team. One staff member said, "I feel we look after people. I'm happy to come to work." Another staff member said, " Staff have been very supportive." Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. This ensured staff were kept up to date with events. A separate heads of department meeting was held each week for broader topics to be discussed such as supplies and budgets. Staff told us they felt included in the running of the home, as heads of departments passed on messages. This was reflected in records seen. The registered manager was seen walking around the home during our inspection. They talked with people who used the service and visitors and knew a lot about each person.

There was sufficient evidence to show the home manager had completed audits to test the quality of the service. These included medicines, care plans and infection control. Staff were able to tell us which audits they were responsible in completing. Where actions were required these had been clearly identified and signed when completed. Accidents and incidents were analysed monthly to ensure people were not at risk and staff told us that they amended people's care plans when necessary. The registered manager completed an overview report weekly. This included trends identified such as call bell improvements and training. Representatives of the company also completed audits monthly to check the home was abiding by the policies and principles set out by the provider and people were being looked after safely. Any ongoing actions were identified, who was responsible for completing and when. This ensured needs and problems were kept under control and addressed as soon as practicable.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

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.