Hutchings & Hill Care Ltd

Seaview Haven

Inspection report

Oaktree Gardens
Highfield Road
Ilfracombe
Devon
EX34 9JP

Tel: 01271855611
Website: www.SeaviewHaven.co.uk

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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?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 5, 12 and 14 September 2018.

Seaview Haven is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Seaview Haven is a care home which previously belonged to the local authority. It has undergone an extensive refurbishment and provides a high standard of fixtures and fittings. This was the provider's first inspection.

The service was registered for 29 people. There were 27 people living at the home at the time of inspection, many of whom were living with dementia. Seaview Haven is a care home situated in a residential area of Ilfracombe. It has accommodation sited over three floors, some rooms with extensive sea views. However, at the time of inspection the upper floor was not in use, except for one person who had chosen to live on that floor.

The service had a manager who had registered with the Care Quality Commission (CQC) in July 2018. A registered manager is a person who has registered with the CQC 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 registered manager was supported by the nominated individual and the deputy manager who formed the management team. They had worked together for the previous four months.

The service had been registered with the CQC since October 2017. In that time, two other previous managers had led the service. However, both had left within a short space of time and had not been registered with CQC. This effectively meant that since the service was registered, it had operated without a stable registered manager in place until recently.

Despite the management team working closing together, there was a definite lack of leadership and oversight of the whole service. This was due in part because the management team had previously managed services with a different type of service user group with a different type of need.

People's health, safety and welfare were put at risk because there were many risks to the environment, both inside and outside of the building. People's individual risks had not always been assessed and managed in a safe way. There was a lack of quality monitoring and inconsistency in record keeping.

Because of the seriousness of the concerns found on the first day of inspection, we wrote to the provider and management team setting out our concerns. They recognised and acknowledged the concerns raised. They were upset and disappointed at the findings but agreed with the judgements. They recognised action was

required and put together an action plan with timescales for action. They confirmed their commitment to addressing all concerns and their assurances to improve the safety of people living at the service. On the second and third day of inspection, all the concerns had a plan to put them right. Some of the work had already been completed and some areas made safe whilst a permanent fix was made. Health and social care professionals had been contacted and arrangements for assessments to be made.

People were not protected from unsafe and unsuitable premises. The provider's quality assurance systems did not take place regularly and had therefore not picked up the deficits and shortfalls identified during the inspection. The provider had not completed an environmental risk assessment or monitoring checks to ensure the environment was safe. In particular, we highlighted risks due to open access to unsafe areas both inside and outside of the building. No monitoring checks had been undertaken in relation to bedrails and beds to ensure they were safe and at the correct settings for the individual person. Checks on window restrictors were in place but these had not identified all the windows in the building which did not have one in place to prevent people falling out of windows.

There was an ineffective system in place to protect people from the risks associated with their care and health needs. There were no risk assessments regarding people's nutritional needs, skin integrity, falls or safe moving and handling. Therefore, it was not possible to provide consistent guidance for care staff on how to support people with their care in a safe and proper way.

People did not receive person-centred care that met their needs and reflected their choices, preferences and interests. Care plans did not contain information about people's care needs and had not been updated to reflect people's changing needs. People and relatives had been involved in care planning but these had not been regularly reviewed. Where people needed specialist professional guidance, these had not always been referred in a timely way subjecting people to increased risks.

Staff did not always treat people with dignity and respect, although people and relatives were complimentary of staff. Some staff had developed effective interactions between themselves and people.

People received an appetising diet that gave choice and preferences. Residents could choose what meals they would like on the menu. However, for people who received a pureed diet, it was not always clear why they needed it and it was presented in a manner which meant people were unable to identify specific tastes.

People and their relatives gave positive feedback about the service and felt safe and cared for. During our visits, the majority of staff were kind and caring in their approach to people and treated them with respect. However, they had not ensured people's dignity was always maintained. Some people had their call bell out of reach and other areas of the home had no call bell fitted to allow people to call for assistance.

There was a divide between the management team and the care staff team. Staff spoke openly about this and the management team were in the process of addressing the issues.

There was a limited range of activities on offer. These did not always include activities which were in line with people's preferences, choices or hobbies. People living with dementia did not have activities which were most suitable to them.

The majority of people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, some people were cared for in bed in their 'best interests' but there was no reason why these people could not get out of bed.

Staff understood how to protect people from abuse and who to report any concerns to.

Staff struggled to understand the concept of personalised care and at times looked upon their role as task based. They had received training but the management team were unsure as to how valid the training had been and were looking at other types of training materials. Staff received supervision in their roles but this was overdue. The management team had introduced a competency based supervision by overseeing staff's care practice and giving feedback.

The management team were a strong team of dedicated and caring senior staff. They acted as role models for the staff but there was a lack of respect shown from some staff which made an unpleasant atmosphere. Care workers felt unsupported and were not always motivated in their work. However, the management team were addressing this to drive the service forward and make Seaview Haven a place of choice for staff to work.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made three recommendations about the monitoring of staffing levels, reviewing how dignity was promoted, seeking current guidance on activities and a suitable environment for people living with dementia.

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 protected from a number of risks identified from unsuitable and unsafe premises.

Staff had not completed individual personal risk assessments for people to assess how to reduce risks as much as possible.

Medicines were not always safely managed.

People were protected by staff who were aware of how to recognise abuse and the correct action to taken.

There were enough staff on duty but not always deployed to work in the right places.

Improvements had been made to ensure prospective staff underwent a safe recruitment process which included all the necessary checks being undertaken.

Accidents and incidents were recorded and analysed for any trends.

Is the service effective?

Requires Improvement

The service was not always effective.

The design and adaptation of the premises, together with a lack of signage, colour schemes and decorations did not provide an effective environment for people living with dementia.

Care staff received knowledge and skill training, but there were gaps in some areas of their practice.

People had access to community professionals, but other specialist professionals had not always been contacted in a timely way.

Staff supervision took place but this was overdue. A new system of monitoring hands on practice had been introduced.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff did not always treat people with dignity and respect.

There were some good interactions between people and the staff who supported them.

People and relatives were complimentary of the staff who supported them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans were inconsistent and did not always reflect the current level of care being delivered.

People who were 'end of life' did not always have their planned and recorded so there was no assurance their needs were met.

There was a lack of meaningful activities which did not meet the needs of the people living with dementia.

There was a complaints system in place but records were not always held.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were at risk because audit and monitoring systems did not ensure they received a safe, effective, responsive and caring service.

Records relating to the running of the service were not always in place and reviewed.

There was a 'them and us' culture at the service with the management team and care staff not working together.

People's views were sought and acted upon.

Seaview Haven

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 checked 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 comprehensive inspection took place on 5, 12 and 14 September 2018. The first and second visits were unannounced and the third visit was announced.

Two adult social care inspectors carried out the inspection and were accompanied by an Expert by Experience on the first visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service. This included safeguarding alerts and statutory notifications. A notification is information about important events which the service is required to send us by law.

This was a routine comprehensive inspection and the first inspection carried out by the Care Quality Commission since the service was registered on 31 October 2017.

There were 27 people living at the service during the inspection. We saw each person who lived at Seaview Haven and spoke with 16 people and 5 relatives. We spoke with the management team who consisted of the nominated individual, the registered manager and the deputy manager. We spoke with 12 staff members which included a senior care worker, care workers, housekeepers and a cook. We also spoke with two visiting community nurses and a social care professional.

We also reviewed information about people's care and how the service was managed. These included: seven people's care files and medicine records; three staff files which included recruitment records of the last staff to be appointed; staff rotas; staff induction, training and supervision records; quality monitoring

systems such as audits, spot checks and competency checks; complaints and compliments; incident and accident reporting; minutes of meetings and the most recent quality questionnaire returned.

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 to us.

After the inspection, we contacted the commissioners, local safeguarding team and health and social care professionals. We received two responses.

Requires Improvement

Is the service safe?

Our findings

People were at risk of receiving inappropriate and unsafe care. This was because risks to people's physical safety, along with risks to their health, were poorly managed.

On our first day, risks to people from the environment both inside and outside of the building had not been previously identified, managed or recorded appropriately. Internal risks included: exposed electrical wiring; floorboards missing; accessible materials hazardous to health; unrestricted windows; radiators without covers; unrestricted access to a concrete staircase; unsecured doors giving access to unsafe areas; not all exit doors linked to the call bell system; lack of signage to advise people of unsafe areas; lack of signage showing fire exits, and uneven floors.

External risks to the outside of the building included: partially restricted access to a set of steps to the garden area; open access to the lawn where there was a unseen sheer drop from the flower and shrub border, and open access to this area directly from the communal area and people's bedrooms.

The service had a call bell system in place but we identified this system did not cover all the home with some people unable to call for assistance from communal areas such as the main lounge and dining room. Some people who were nursed in bed had hand held call bells. However, these were found at times to be out of reach on all of the three days. Some were coiled on the wall, some were out of reach and some were on the floor.

These concerns were identified on the first day of inspection and fed back to the provider and management team. We received an action plan from the service as to how they would address the concerns. When we returned on the second and third days, the risks had been mitigated and the impact on people significantly reduced by the action taken. Action taken included: a visit from the Devon and Somerset Fire and Rescue Service; a visit from the alarm system company to extend the call bell system; fixing locks to doors which needed restricted access; putting up signs to advise of risks; putting up signs to advise of restricted access; making good floorboards, and making safe electrical wiring. Further work was required to restrict all windows, cover all necessary radiators and secure the risks to the garden area. Wireless doorbells had been purchased for use in the communal areas until the call bell extension work had been completed.

People' personal individual risks had not always been assessed appropriately, comprehensively and were not up to date. These included people's risk of falls, their skin integrity, nutrition, use of bedrails and what support they required when moving. This impacted on people not having control over their lives and their independence. For example, one person was permanently cared for in bed. The management team confirmed there was no reason why they could not get up, sit out in a chair or visit the communal areas. Three people who required it, did not have an up to date moving and handling plan from a trained professional.

People had bedrails in place. There were no records in relation to whether bed rails or specialist beds had been risk assessed for safety for each person to minimise the risk of them getting trapped or falling. One

person's care records said it was unsafe to use bed rails, but these were in place. This meant people were at risk of entrapment. The service had not considered using other equipment which may have been more suitable, such as adjusting the height of the bed.

Two people who were nursed in bed and had air pressure mattresses in place to prevent further skin damage. However, they had not been recently assessed for skin damage and whether they had pressure areas, often referred to as 'bed sores'. Also, these mattresses required to be set at the right amount of pressure for the weight of the person. People had not been weighed regularly so the mattresses were at the incorrect settings which left them at more risk of skin damage. For example, one person had not been weighed for four months; their pressure mattress was set for a person weighing 170 kilogrammes and they weighed 55 kilogrammes. Mattress pressure settings were not checked or recorded. This meant people could be at risk of skin damage by using an inappropriate mattress set at an incorrect setting. There had been several instances of low grade pressure sores at the service earlier in the year. However, the management team were unaware of the current numbers of people with any grade of pressure sore. They confirmed they would re-assess each person to find out if they were at risk of skin damage.

These concerns were discussed with the management team during the inspection. We received an action plan from the service as to how they would address the concerns. When we had completed the inspection, the risks had been mitigated and the impact on people significantly reduced by the action taken. Action taken included: requests for occupational therapy assessments for the three people who required it; requests for speech and language therapy assessments for the people who ate pureed food; each person living at the home had now been weighed; a system put in place to put the air mattresses at the right setting; a system put in place to check the air mattress settings and bedrails each day; a system for the appropriate assessment of risk by using bed rails, and a plan to review each person as to their skin integrity.

Following the inspection, we contacted the local safeguarding team, community nursing team and care homes education team to inform them of our findings. The service also had a planned visit from the quality assurance and improvement team of the local authority to support them to move forward.

Medicines were not safely managed. Medicines were kept secure and in a designated room and fridge. Regular monitoring of the air and fridge temperatures was required. However, there were several gaps on the records when the temperature had not been recorded. This meant the service could not guarantee people's medicines were being kept at the correct temperature.

The medicine administration records (MAR) were filled in correctly for people's routine medicines. However, regarding medicines which required additional checks, the amount held was more than that recorded in the record book and MAR chart. The MAR chart also showed on two occasions that one of these people was only given one tablet, but the prescribed number was two. There were no records to explain why this had happened. Another person had patches prescribed for pain relief. The MAR chart showed one had been given out and used but this had not been recorded in the record book.

There were 'just in case' medicine boxes in place for people who might require these at the end of their life. However, these were not secured and not routinely checked to make sure they contained the right medicine.

We asked care staff how they knew where to apply creams to people's skin. They said they had tried a system of recording on a separate file but this had not worked effectively with missing signatures. The senior care worker planned to put in place a laminated chart to go in to people's bathrooms to show where the skin cream was required. At the time of the inspection, directions on where to apply creams was given by

'word of mouth' and staff's knowledge of people with no written guidance or body maps in place. This meant people might not be having their prescribed creams applied consistently and correctly.

People did not receive safe care and treatment because:

- Risk assessments relating to the safety of the building were not managed safely
- Risk assessments relating to people's personal safety were not managed safely
- Medicines were not managed safely

These were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A senior care assistant was responsible for managing medicines at the service. A pharmacy audit had been carried out by the dispensing pharmacy in April 2018. This had identified points for action which had been completed but had not been embedded in practice, such as a lack of monitoring of the air temperature where medicines were stored.

We discussed these issues with the management team who confirmed they would fully address the issues. Some of the required actions had taken place before the end of the inspection, such as a review of 'just in case' boxes, improved record keeping and monitoring. This reduced the impact to people regarding the risk of giving unsafe medicines.

The management team were in the process of reviewing the staffing levels. Whilst there appeared to be enough staff on duty, they were not always deployed to work correctly. For example, we had to find staff to take one person to the toilet, find a staff member to help someone off the floor when they had fallen and assist someone who was walking in a state of undress in an upstairs corridor. All three were heard calling for "help". The majority of staff seemed to spend their time on the ground floor and were not as visible on the upper floors.

The management team used a dependency tool linked to the electronic care planning system. This identified the staffing levels required based on people's increased or decreased needs. However, the management team did not consider this to be a true reflection of people's individual care needs and were looking at alternative ways to assess the correct staffing levels.

People and care staff said the numbers of staff were too low at times. Care staff said they were unable to spend time with people and the focus of their work was on the task of completing personal care as quickly as possible due to the numbers of people requiring their assistance. However, they did say a lot depended on which staff team they were working with as to how the effective the care shift ran. When we asked if this had a negative impact on people, one care worker said, "Yes, people are not getting their baths." Another two care workers asked the same question said, "Yes, we are always rushing, we need more time to spend with people" and "Yes, it is chaos every day, I can't give people the time they need, it takes time to do things properly for people." On our first day we saw one person eating their breakfast at 11.30am in the dining room. When we asked a care worker if this was their choice, they said it was because they were running late assisting people to get up. On the third day, two people who were cared for in bed did not receive their personal care until almost lunchtime. They were seen with food debris around their mouths and bedding stained from drinks spilt earlier.

There were six care staff on duty each day to provide personal care for up to 29 people, some of whom needed two staff. There was one senior care worker on duty as part of the six staff members; they were not

supernumerary. However, when they had their days off, there was no senior care worker on duty. This meant there was no senior person on duty on the floor at all times overseeing the care delivery.

One care worker said care staff were expected to complete their electronic note recording as soon as they had completed any tasks. However, they said this did not always happen as they felt it was their priority to assist people to get out of bed as quickly as possible. They said, "Every day I don't get to spend quality time with people, I am rushing around." Two care workers said staff were expected to stay on after their shift if they had not completed their care notes on time. They said, "Sometimes we don't get chance to write our notes up and we are told it is our fault and we will have to stay on." Another care worker said lunch breaks were not always available to be taken and one person had received a fourteen minute lunch break within a 12 hours shift."

We discussed the staffing issues with the management team. The management team had only really worked together as a team for four months; they had inherited staff levels and capability issues from the previous management of the service. They had recently had to let two staff leave as they were unsuitable to work at the service. The management team worked on the floor to support care staff in times of unplanned sickness and absence but this had not been routine. This also gave them an insight as to how busy the care staff were. They had acknowledged there was a lack of oversight of the staff team and a lack of co-ordination for the care workers. They had made arrangements to employ a second senior care assistant to work on shift alternative to the other senior care worker. They felt some of the problem was not always down to numbers but the skills of individual staff which they were addressing. They had also introduced a daily 'huddle' which took place at 11 am which all staff were asked to attend. This helped to inform the management of any issues or concerns, whilst checking on the work progress.

We recommend that the service monitors the staffing levels and their deployment regularly to ensure people's needs are met in a timely way.

A fire risk assessment had been completed in September 2017; points of action had been required and addressed. At the time, the service was not open and still in the process of refurbishment. It was reviewed in March 2018 but this showed further action was still required and ongoing. Devon and Somerset Fire and Rescue Service visited the premises on 3 September 2018. They had no concerns over the fire safety of the home and the risk assessment in place.

Records showed the required checks relating to fire safety were undertaken regularly. Tests were carried out in different zones each time. Staff received fire training and equipment was maintained satisfactorily. The lift, call bell, emergency lighting, equipment and hoists were services regularly. Other checks related to health and safety were undertaken, such as tests for Legionnaires disease, except for portable appliance testing. The management team were aware of this and the maintenance person had recently received training to undertake this.

The majority of people had an up to date personal emergency evacuation plan (PEEP) in place which showed the help they required to evacuate the building in the case of an emergency. However, not everyone had one in place. The management team confirmed they would review each person's needs as soon as possible and update the PEEP as required.

Some safe recruitment practices were followed before new staff were employed to work with people. This included undertaking checks of identity, qualifications, and undertaking a Disclosure and Barring Service (DBS) criminal record check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, gaps in

employment history were not routinely discussed and made it difficult to assess whether the care worker was suitable to work with vulnerable people. Also, proof of identity was not held on file. We discussed this with the management team who confirmed they would add this information to their recruitment process immediately. Following the inspection, the management team confirmed they had checked the recruitment levels of all staff to ensure they were all in order.

Staff had completed infection control training and had access to personal protective equipment, such as gloves and aprons to reduce cross infection risks. However, there was some infection control risks we identified during our first day of inspection. For example, one person's soiled bedding and personal clothing was left on the carpet of the hallway not bagged. There was a lack of appropriate bins, hand wash and disposable wipes in communal toilets. Keys had been left in the empty liquid soap containers which were a further risk to people living with dementia in the home. There was a lack of equipment available to transfer soiled laundry from each of the three floors to the laundry room. Staff were using small, flimsy pedal bin bags. We also saw there was only one sling in use for people which posed both a safety risk and an infection control risk. Staff were varied in their answers when we asked if people used their own hoist sling or a shared one.

We discussed this with the management team who agreed to act immediately. By the third day of our inspection, new linen skips had been purchased for each floor, with three separate apartments to identify and keep laundry separate. Disposable red plastic bags for contaminated linen were available. Action required to supply each bathroom and WC with appropriate equipment was being undertaken. Following the inspection, the management team have put in place named slings for people, of the right type and size.

There was not always enough suitable equipment to support people with a moving and handling need. There were people on all three floors of the home who might require the use of a hoist. On our third day, one person fell in their bedroom on the ground floor. It took a member of staff ten minutes to locate the hoist and bring it to the person's bedroom. Following the inspection, the management team have confirmed they have purchased a new hoist which can also weigh people.

Staff had received safeguarding training and were aware of how to recognise the different types of abuse. They knew who to contact and the right action to take. The service had an up to date safeguarding procedure. There had been three safeguarding concerns in the last 12 months. These were related to the quality of care delivered and were all resolved.

All accidents and incidents are reviewed by the management team who identified any trends or patterns related to these. The management team confirmed they wanted to break this information down further so they could see if it related to a certain time of day, when certain staff are on duty or due to environmental issues.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always met by staff who had the right competencies, knowledge and qualifications. The training matrix showed there was a deficit in some training required. Whilst the majority of staff had undertaken the training required of them, records were not available to confirm other staff had completed training.

The management team had identified training deficits and were in the process of planning a programme to catch up with staff training. The registered manager previously delivered the training at the service, which was supplemented by outside training professionals, such as the care home nurse education team. The management team were looking at other training organisations that might have more in-depth training available, such as those relating to medicines. Nobody at the service was trained to deliver safe moving and handling; however, the registered manager had plans to undertake a refresher 'train the trainer' course so they could do this in the near future.

Staff had received induction training to support the differing needs of people using the service. Despite this, the impact on people was low because they told us staff were trained and undertook their jobs in a professional and knowledgeable way. No accidents or incidents relating to this had been reported in the service or to outside organisations.

New care workers who had no care qualifications were supported by the registered manager to complete the 'Care Certificate' programme (introduced in April 2015 as national training in best practice). Two care workers were due to start this soon.

Records showed staff received supervision and an annual appraisal on a two monthly basis. However, the records also showed supervision was overdue for the majority of care staff with the most overdue by 81 days and the lowest two days. The management team were aware of this and had recently introduced competency and spot checks on care worker's practice. A member of the management team each day worked alongside a care worker for a shift and assessed their hands-on care practice. Following the shift, both the care worker and manager met to discuss their performance and feedback positive and negative feedback. The management team said this would help them capture more pertinent information rather than having an office based supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found they were. People said staff gained their consent before carrying out any care or support.

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 authorisation procedures for this in care homes

and hospitals are call the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made to the supervisory body but none yet authorised.

Staff had undertaken training on the MCA and DoLS. Three care records showed good examples of the use of the MCA and best interests decisions (BID) made. These were clear and easy to understand. For example, one care record showed the BID had been made with the next of kin and the power of attorney.

People had access to healthcare services for ongoing healthcare support. People were seen regularly by the local GP and attended regular appointments with the dentist, optician and chiropodist. One person said, "… If they think I need to see the doctor, they'd (staff) arrange it." Another person said, "I know I don't always recognise when I'm unwell these days, so the helpers do things like my medicines and checking if I'm okay every day and calling the doctor if I'm ill." However, referrals to specialist professionals were not always made (see under 'responsive' in report).

People's medical history and health care needs were recorded when they were admitted to the home. Care records contained details of people's GP's and other health care professionals for staff to contact if there were any concerns about a person's health. The service used only one GP practice in the area. This was because other GP surgeries declined to offer a service to people at the home. The management team had experienced some problems recently with requesting GP visits and getting through to the doctors at the surgery. A meeting with the local GP's had been planned to address this.

People were supported to eat and drink and were complimentary of the food served. Comments included, "It's the type of food I used to cook but probably better than I often could afford. It's always hot when it arrives and we can select something else if we don't like what's on the menu on a day" and "I have no complaints about the food; not anything really but certainly not on that score. I'm eating really well now." As a result of a recent residents meeting, food choices had been added to the menu which people liked. Both people and relatives said this had been a positive move and one said, "…I think meal choices rotate every three weeks and there have been new dishes introduced over time and more choices at every meal."

Two cooks worked at the service and prepared breakfast, lunch and tea each day. They knew people's likes and dislikes and any allergies. People ate what they wanted for breakfast and we saw this ranged from simple cereals to a cooked breakfast. People who ate their lunch in their bedrooms had their lunch earlier so staff could assist them. Lunch consisted of a choice of four meals which people chose the same day. Food appeared appetising and nourishing, except for the two people who received a pureed diet. This had all the food pureed together which meant people were unable to differentiate between different food items, such as meat and potato. The food did not look appealing. We discussed this with the management team who agreed to follow this up. People received a light tea of soup, sandwiches and a hot choice such as spaghetti on toast.

The dining room experience was not a friendly or sociable experience. There was a quiet atmosphere with nobody chatting. On the first day blackcurrant squash was offered to people. An alternative of orange was offered which some people requested. The care worker had to fetch this from the kitchen but this did not always arrive. One person twice asked for a cup of tea but was given a glass of squash with no words spoken. After they had finished their main course and dessert, they again said, "I would love a nice cup of tea now please" and again later said, "My tea hasn't arrived yet." The tea trolley arrived only after each person had finished their dessert. This meant this person had to wait for the progress of the trolley to where they were sitting in the dining room.

On the second visit, people had a choice of drinks available. For example, people were offered blackcurrant,

orange or water to eat with their lunch. One person asked for lemon and the care worker left and immediately brought them lemon juice. People sat down to eat their meal at 1pm. Food was not started to be served until 1.20pm and people were becoming impatient of waiting. There was more banter on this occasion as a care worker took the time to sit with people and enter conversation with them.

Tables contained no table cloths and exposed well-worn tables. No specialised cutlery was used, for example plate guards which would be helpful for some people. No music played and the dining room itself was bare and not very homely.

We discussed the lunchtime experience with the management team who confirmed they would review this and make it a more enjoyable occasion for people.

The building was previously a care home. It had undergone an extensive refurbishment programme both internally and externally. It was currently registered for 29 people as some of the rooms in the building had not yet been successful in gaining registration from CQC.

The building itself was very pleasant and smelt fresh and clean. It had a selection of communal areas for people to sit in and quality furniture. However, the room had been decorated overwhelmingly in grey. For example, grey walls, grey carpet and grey doors. Whilst it looked freshly painted and clean, this colour scheme was not suitable for all the people living at Seaview Haven. Some of the people lived with dementia and these colours did not help them to find their way around the home. There was also a lack of signage on their bedroom doors, many of whom had no pictures on to help people recognise them as their own bedrooms. There were long corridors which would prove confusing to these people.

We recommend that the service considers current guidance on suitable environments for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Staff did not always treat people with dignity and respect, although management and care staff strived to provide a caring and kind service to people.

One person who was sitting in the communal lounge wanted to go to the toilet. They waited 15 minutes for a care worker to take them. They were unable to press the call bell for help as there was none fitted in the lounge. Therefore, they shouted for assistance but with no response. They said, "I expect to be looked after … if we had a control thing to press … there's no buzzer … we should have a call bell instead of shouting."

A second person told us of having no hot water to get washed with. There had been a problem with the hot water in the service following disruption to the gas supply. The person said, "I was wet and cold … I was washed with cold water and it was not nice … I have only just stopped shivering."

A third person was calling for "help" from their bedroom which had the door closed. Staff told us they shouted all the time. When we asked if they could check the person was not in distress, they found the person laying horizontal across their bed with their dirty incontinence pad taken off. Staff then went to assist this person.

A fourth person asked for a drink as they were thirsty. When we told a care worker, they looked at their watch and told us "It's OK, they are due a drink in ten minutes anyway" and carried on with their work. When we advised they wanted a drink now, they said "I'll sort it."

A fifth person was using the toilet and a care worker entered without knocking first. They left the person exposed and on view to other people, visitors and relatives.

We overheard staff referring to people as "the feeds". When we asked the care worker what these derogatory comments meant, they explained these were the people who had lunch in their rooms and needed assistance. Some staff referred to people as their room numbers, for example one care worker said, "Room 2 has been done". This meant they had received their personal care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All these were discussed with the management team who took immediate action. Following the inspection, they informed us one of the staff members had left and another had been spoken with. They had also employed an extra member of staff to monitor the lounge and dining room to ensure people were supervised at all times and to get assistance when needed.

People and relatives were complimentary of the care staff who supported them. When we asked people what the liked about Seaview Haven, one person said, "I came in here because I knew I wasn't caring for myself … the move has turned me round … being here is giving me the feeling that I matter". A relative of a

person recently admitted to the home said, "It all went really well on admission, they're (person) much better than they were, much livelier, more communicative, not so down in the dumps." Another relative said, "(Family member) received very good care here … I think (family member) is happy with the staff. I am happy with the staff. They are willing to help with problems and are on the ball with stuff."

There were some caring and considerate interactions seen between people and care staff. For example, one care worker engaged in conversation with several people and asked questions about their previous lives. People enjoyed talking with them. Another care worker enjoyed banter with a person in the lounge.

Care workers spoke warmly about the people they cared for. The majority of people were local to the area and care staff knew their families and friends. They demonstrated kindness to people and gave people a hug when they needed it which people clearly enjoyed.

Requires Improvement

Is the service responsive?

Our findings

People were not at the centre of the care they received. Care records did not reflect people's need, choices and preferences fully. Although some personal care details were thorough, there were a number of inconsistencies and omissions seen. These included inaccurate and not up to date recording of: people's weights; bed rail assessments; air mattress bed settings; wound care details; diabetic monitoring records; catheter care records; colostomy care records, and end of life records. The management team were not always aware of people's current care and support needs.

The management team had recognised the care recording system needed to be reviewed. This was the reason why the electronic care recording system had been purchased. This had been in place for approximately four months. The service had moved from a paper based care record to an electronic care record. This move was still in transition and not all care records had been transferred over. However, of the care records which had been completed, there were discrepancies and poor record keeping. The care delivered did not correspond with the planned care recorded.

The level of guidance in each of the sections of the electronic care records was inconsistent. For example, one person required monitoring for daily fluid intake and output. The care plan stated that fluids needed to be encouraged and offered two hourly. However, fluids had not been given as per this plan and no target fluid had been identified. A second person who required fluids two hourly was noted to have drunk only approximately a quarter of the fluids recommended in 24 hours. This meant people may be at risk of not being hydrated as they should. A third person who was cared for in bed, had their last weight recorded in May. However, in other areas of the care plan their weight had been recorded in March and August. The nutritional information was therefore unreliable as it appeared as if the person had not been weighed for four months. This person was also nursed in bed with an air mattress set at over three times their actual weight. A fourth person ate a pureed/soft diet; this was not reflected in their care plan. No referral to the speech and language therapist had been made despite the care plan saying, "major problems with chewing and swallowing." This meant the person was at risk of receiving the incorrect inconsistency of food which could cause them to choke. However, this was related to a lack of record keeping. The risk and impact on people was reduced as staff knew how to meet individual people's needs well.

Following the inspection, the management team confirmed action had been taken to address all the concerns raised and were monitoring people more closely. Occupational therapy assessments had been carried out for three people, together with safe moving and handling risk assessments. Since then, the management team informed us one person had been helped to sit on her bed to eat their own meal without the assistance of staff which they enjoyed and gave them a sense of wellbeing.

People did not receive a person centre care because:

- Care records did not reflect people's current care and support needs
- There was a lack of care planning for people who were 'end of life'
- Poor record keeping

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives were involved in the planning and reviewing of care records. Relatives were kept updated with any issues or concerns. One relative had a close working relationship with the service and was extremely involved in the care of their family member. However, there was no system in place to ensure care plans were regularly reviewed to update them with people's changing needs. This meant the care plans did not accurately reflect the current individual needs of people.

Daily records were made and these were variable in the information recorded. Some contained very clear concise information but others contained minimal information about how people were each day. Care staff had made entries but these were not always meaningful or showed the detail required. For example, people's diet and fluid intake. One entry said, "…two teaspoons tomato and basil soup, four teaspoons strawberry mousse, four teaspoons vanilla ice cream" whilst another said, "gammon, chips and peas for lunch".

Handover between staff at the start of each shift ensured information about people was shared. The management team had also introduced an 11am 'huddle' where all staff gathered in the office to discuss the running of the shift and any problems. This had been introduced to improve communication between the management team and staff and to provide an update on people's current health. For example, at one huddle, care staff reported one person had sore skin which was acted upon.

The service cared for people at 'end of life'. There was an inconsistency in the quality of care records for these people. For example, one person's care record contained no information relating to their individual wishes, choices and preferences. It did not contain any information to guide care staff how to support this person in a consistent way. Another person, however, had good detail recorded in their 'end of life' paper care records as to how they wished to be looked after.

The management team told us five people were 'end of life' and had not been out of bed for several months. However, all these people did not present to be end of life. During our first visit, one of these people was asked if they would like to get out of bed which they did; they spent some time in the communal lounge being amongst other people which lifted their mood greatly. On our second and third visits to the service, the GP had been contacted for the other people. Only two of the five people were considered to be at their end of life and there was no reason why the remaining three people had to remain in bed. Daily notes of one person read, "… (GP) has suggested that there is nothing to suggest that end of life is imminent and there is no medical reason why (person) cannot get out of bed as and when they want."

We looked at how the provider complied with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people wore their spectacles and hearing aids and were spoken to in a way they preferred. For example, one person who chose not to wear hearing aids, requested staff raised their voice when speaking with them so they could hear.

The provider had a complaints system in place. The management team told us all complaints were investigated and outcome letters sent out to the people concerned. However, there were no records available at the service to demonstrate this either electronically or on paper. Some of the complaints investigated had been sent via the Care Quality Commission and we had seen the records pertaining to

these. At the inspection, the management team confirmed they would improve the complaint record keeping system immediately. No complaints were received during the inspection but people confirmed they knew how to make one if they needed to. One person said, "I don't complain because if things need doing, they get done".

People were supported to take part in social activities and interests. These included activities within the home. Activities outside of the home were being started and the first trip took place to the seafront for people to enjoy ice-cream. The management team acknowledged the activities programme needed reviewing and designing to meet people's interests and hobbies. The service did have an activity plan in place but this was not a full plan and did not include activities suitable for all of the people living at the home to enjoy. For example, several people were living with dementia. The service had some specific equipment for these people but staff did not use these. The service had an activities co-ordinator who undertook activities but these were not always meaningful. Records were scanty and unhelpful to plan future activities. For example, for one activity the coordinator had documented they had brought in grapes to share with people. This was written in one person's care record, "Popped into (person) with grapes which she really enjoyed. Had lovely chat." Other activities included exercises, quizzes and arts and crafts. The service had a visit from the clothes sale on one of our visits and on another visit, a staff member played a balloon game with people. Some other activities take place, such as a tai chi, outside entertainers and church services which people enjoyed.

We recommend that the service considers current guidance on activities specifically for people living with dementia.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led. This was because there was a lack of robust quality monitoring systems in place which identified deficits in practice, together with a lack of comprehensive record keeping. Before the inspection was completed, much work had already been undertaken to make the service a safe and improved home for people to live. Other work had been planned to take place in the near future and an action plan sent in which gave details and timescales for action.

The service had a manager who had registered with the Care Quality Commission (CQC) in July 2018. They were supported by the nominated individual and deputy manager who formed the management team. They had worked together for the previous four months.

The service had been registered with the CQC since October 2017. In that time, two other previous managers had led the service. However, both had left within a short space of time and had not been registered with CQC. This effectively meant that since the service was registered, it had operated without a stable registered manager in place until recently.

Despite the management team working closing together, there was a definite lack of leadership and oversight of the whole service. This was due in part because the management team had previously managed services with a different type of service user group with a different type of need. This was not helped as systems for monitoring the quality of the service had not been sufficiently embedded in the running of the service. Had they been in place, they would have prevented this system failure.

Many of the deficits in record keeping and shortfalls in practice had not been recognised because a full audit of the systems and practices at the service had not been undertaken. Had this taken place, the management team would have been able to identify the areas for improvement based on a risk system. The management team were aware of some of the concerns found, such as low staff morale, a 'them and us' culture and staffing issues but not others.

The management team had worked very hard to make improvements to the service but these were not managed and completed fully. They acknowledged this deficit and that they had worked on areas of concern as they came up, but moved on to something else before the work was completed. As a result, this had impeded on their ability to complete actions and the service was being led in an unstructured and chaotic way. The registered manager said, "We have addressed so many things but not completed work before moving on to other things which needed our attention … I literally don't know where to start."

The management team were disappointed and visibly upset about the findings of the inspection and that people were not receiving the care they should be. In discussions and feedback throughout the inspection, they acknowledged and agreed with all of the concerns we highlighted. They were a dedicated, motivated and professional team of people who were keen to put things right. The management team had a lack of thorough oversight and continual monitoring of the service. For example, the last audit for infection control was carried out in May 2018 and no recent audits on medicines management had taken place.

The provider had contracted a 'mock inspection' which took place in March 2018 by a private organisation. This was used to assess the current Care Quality Commission compliance status. The rating of the service was requiring improvement in four out of five areas, with good in one area and an overall rating of 'requires improvement'. As a result of that inspection, an action plan was drawn up to address the issues identified. The majority of these had been rectified. However, some of the deficits at that private inspection were still found to be outstanding at this inspection, such as gaps in care plans and lack of personalisation, lack of meaningful activities and lack of audit schedules in place.

There were deficits in record keeping throughout the service. For example, those relating to medicines, care, complaints, risk, staff training and end of life care. Care records did not consistently describe people's risks, needs, preferences, choices and personal histories or how these should be addressed.

The providers had some contact with the service in an advisory role, although they had been involved recently with the issue of low staff morale and staff complaints. However, they had a general lack of oversight of the service and its shortfalls relating to the monitoring systems and processes in place. They did not visit and carry out any monitoring visits themselves and had failed to see the deficits in the overall management and governance of the service. Had this process been in place, this would have also helped to identify deficits before they had escalated.

The service did not have good governance systems in place because:

- There was no regular assessment and monitoring systems in place to measure the quality and safety of the service
- Deficits and shortfalls in practice had not been identified and resolved
- The risks relating to health, safety and welfare of people had not been addressed
- Accurate records in relation to people's care had not been completed and actions taken recorded
- Shortfalls in practice had not been evaluated and improved upon
- Plans to improve the standard of the service were not in place
- The management team had limited management oversight of the service
- The providers had no general oversight of the service

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture and the values of the service were not being assessed, monitored or reviewed. When we asked the management team what their vision was for the service, they were unaware of what this was and how it related to the statement of purpose.

People's opinions were sought and they were encouraged to give feedback about the service. One person told us "At the last resident's meeting, we asked for more choices and more variability in the menu. So, they do listen!" One relative said the management team had listened to what people had said about the service the last quality assurance questionnaire sent out to people had been analysed and any action required taken, such as issues regarding cleanliness, communication and activities.

Staff meetings were held but these were not always regular. The last management team meeting had been held in May 2018 and the last care staff meeting in June 2018. Staff were given the opportunity to influence the service, for example through feedback, handover and meetings. The management team were aware of the poor communication between them and the care staff. A full site meeting for all staff was planned for all

staff to attend in October 2018.

The providers had some contact with the service in an advisory role, although they had been involved recently with the issue of low staff morale and staff complaints. They left the running of the service to the management team on a day to day basis.

All equipment had been maintained and serviced in line with their contracts. A recent fire risk assessment had been carried and all emergency equipment such as: smoke alarms; fire extinguishers; emergency lighting; call bell; portable appliances and hoists had been maintained safely. A legionella check had been carried out. Thermostatic control valves had been fitted to hot water taps, with the temperature of the water randomly checked. The Food Standards Agency had inspected the service in January 2018. It had awarded the service the highest score rating of five stars.

Despite the above concerns, people and relatives were positive about the home, along with the caring attributes of the majority of the staff group. They considered the way the service was led was "probably fine" and that it was heading in the right direction. People told us they were confident the service would continue to meet the needs of their relatives. One person told us "Out of all the care homes I looked at, I think this one is the best … the staff make you feel safe and everything is open and easy to access."

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 9 HSCA RA Regulations 2014 Person-centred care People did not have a comprehensive, personalised and up to date care plan in place Regulation 9, 1,3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not have risks assessed relating to their health, safety and welfare People did not receive their medicines in a safe way Regualtion 12, 2 a,b,g

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality of the service was not continually monitored and improved. The risks to people were not mitigated relating to the health, safety and welfare of service users. Accurate records were not kept pertaining to the running of the service.

Regulation 17 a,b,c,d