Seahaven C.H. Ltd

Seahaven Care Home

Inspection report

146-148 Beach Road
South Shields
Tyne and Wear
NE33 2NN

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15 June 2017

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16 August 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 June 2017 and was unannounced. This meant the provider and staff did not know we were coming.

Seahaven Care Home is a residential home which provides personal care for up to 28 people. There were 21 people living there at the time of our inspection, some of whom were living with dementia and mental health needs. The accommodation is over three floors.

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (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

At our previous inspection in October 2016, we identified breaches of regulation 12, safe care and treatment, regulation 17, good governance and regulation 18, staffing. The provider had not fully assessed the risks to the health and safety of people who used the service. The provider failed to ensure that the premises were safe to use for their intended purpose. We found the provider did not appropriately manage the deployment of staff at meal times to ensure people received dedicated support when they needed it. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this unannounced focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. The inspection was also prompted in part following concerns raised regarding staffing levels, staff's ability to manage behaviours that may challenge, care practices, environmental issues and governance within the service. This report covers our findings in relation to these issues and the three key areas of safe, effective and well led.

During this inspection we found the provider had made improvements in some areas. However, we found the provider had not completed all the actions set out in their action plan. We found there were continuing breaches of regulations. This was because the provider had not adequately assessed the risks to the health and safety of people who used the service, plans to mitigate risks and to provide personalised care were not specific to the identified risk. Policies and procedures had not been reviewed.

The provider had not ensured staff had appropriate training to support people using the service. Staff supervisions and appraisals were planned and some had taken place. However we noted that some staff supervisions were not taking place in line with the provider's own policy of six times a year.

Areas where substances that are hazardous to health were being used were left unlocked. The premises continued to require refurbishment and repair.

People's personal care records were not always stored securely. Personal hygiene charts were being used, these were not personalised and appeared to be more of a list of tasks to be completed and ticked off.

Records relating to food and fluid intake were not totalled or reviewed.

The provider's quality monitoring processes were not always effective in identifying areas which required improvement.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Access to the stairs had been addressed to ensure people were safe. Key pads were now in place.

The carpet in one person's room had been made safe.

Staffing levels had been reviewed and increased on night duty. Plans were in place to increase the levels of staff on day duty.

The provider had taken the smoking room out of use. Alternative arrangements had been made for people who wished to smoke to do so outside with appropriate shelter.

We found the provider had obtained pictures of food to develop the pictorial menu. The provider had added sensory equipment to one of the lounges to support people living with dementia. People were being supported with eating and drinking in a dignified manner.

Staff were aware of people's needs and could explain how they supported people.

Despite our findings and identified shortfalls, people and relatives were happy with the care and support they received. Comments were very positive about the care home and the staff.

We have carried out two inspections including this inspection over a period of 15 months. We rated the service as requires improvement at our inspections in March and October 2016 and identified two breaches in March 2016 relating to fit and proper person and good governance. At our inspection in October 2016 we found breaches which related to safe care and treatment, staffing and good governance.

At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to regulation 12, safe care and treatment, regulation 18, staffing and regulation 17, good governance.

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's risk assessments did not give specific guidance for staff to follow to mitigate risks.

Some areas of the service looked worn and needed refurbishment and maintenance.

Staffing levels had been reviewed and increased to meet the needs of the people using the service on night duty.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received training to meet the needs of the service.

The provider had developed a pictorial method for people to choose their meals.

Staff knew people well and had an understanding of their needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

A quality assurance system was in place. We noted however, that this had not highlighted the areas of concern which we had found.

People and relatives felt the registered manager was open and approachable.

Seahaven Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We undertook an unannounced focused inspection of Seahaven Care Home on 15 June 2017 to check that they had followed their action plan and to confirm that they now met legal requirements. The inspection was also prompted in part following concerns raised regarding staffing levels, staff's ability to manage behaviours that may challenge, care practices, environment issue and governance within the service. The provider and staff did not know we were coming.

The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of two adult social care inspectors.

Prior to carrying out the inspection, we reviewed all the information we held about the home. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We did not request a provider information return (PIR) due to the late scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

We spoke with local authority safeguarding and contracts and commissioning teams prior to our inspection.

We spoke with three people and three relatives on the day of the inspection. As well as the registered manager, two senior care workers, two care workers and the cook.

We viewed four people's care plans. Two staff files, as well as records and information relating to the management of the service. 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.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we identified a breach of regulation 12, safe care and treatment. We found some areas of the service looked worn and needed renovating. In the smoking lounge on the ground floor the carpet was dirty, had several cigarette burns and was a trip hazard due to being uneven. This meant the provider had not fully assessed the risks to the health and safety of people who use the service. The provider failed to ensure that the premises were safe to use for their intended purpose.

The provider had submitted an action plan setting out how they intended to rectify the breach in regulation 12 which stated the smoking room was to be reviewed. Audits covering health and safety and infection control would be taking place on a monthly basis. Policies and procedures were to be reviewed.

At this inspection we found that some improvements had been taken with regards to the smoking arrangements in the home. The provider had decommissioned the smoking room and an alternative area had been made available for people who used the service who wished to smoke. However other actions had not been completed.

We found the provider had not reviewed the policies and procedures in line with their action plan.

During our walk around the home we observed the laundry door propped open despite this being a fire door. We found a tub containing white powder on the shelf displaying a sticker stating 'stain remover'. A box of washing powder was open on the floor. Toiletries were being stored on the shelf. A number of irons were on the shelf with trailing cables. There was a build-up of dust behind the washer and dryer. The carbon dioxide fire extinguisher in the laundry had a sticker stating 'condemned.' This was addressed with the registered manager on the day of the inspection, who advised a new one was available in the building and the maintenance person would fit it.

The ceiling in the downstairs bathroom was bulging and appeared water damaged. We brought this to the attention of the registered manager who advised this would be addressed by the maintenance person on the day of the inspection. We asked for this bathroom to be taken out of action until this repair was completed.

We found the risk assessment document within people's care files set out a risk but did not contain any detail on how the risk was determined. People's risk assessments did not detail specific guidance and instruction for staff to follow to mitigate the risk. Risk assessments did not contain any meaningful reviews. We saw two sets of risk assessments in some people's files it was not clear what benefit the second set of assessments gave. For example, in one person's file a mental health assessment was scored high, we found no plans were in place on the back of the risk assessment. One person suffered from epilepsy, however records did not set out what staff should look out for regarding seizures. People who may present with behaviours that may challenge or cause anxiety did not have de-escalation plans in place to provide support and guidance for staff to manage such situations.

Audits covering health and safety were in place. However these had not identified the issues we found in the service.

This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Safe care and treatment.

We found some wound dressings in the sideboard in the entrance lobby. We brought this to the attention of the registered manager who removed these on the day of the inspection.

We were made aware of concerns in respect of staffing levels at night, staff's ability to manage behaviours that may challenge, care practices, environment issues and governance within the service. The provider had been asked to develop an action plan to address these issues as part of their compliance with the local authority. Some of the remedial actions regarding staffing are covered in this domain.

The provider had increased the staffing levels on night duty from one senior carer and one care worker to one senior care worker and two care workers. The registered manager advised they were working on increasing the staffing level on day duty to three care workers and one senior carer, care workers were being asked if they wanted additional shifts. The registered manager advised agency staff could be used until new staff were recruited. No agency staff were being used at the time of the inspection.

We reviewed records pertaining to people's care and support needs. We found where staff raised issues and concerns regarding one person's aggressive behaviours, support was sought from relevant health care professionals. Records showed continuous communication with community psychiatric nurses and social workers. We found some personalised care records which contained people's likes, dislikes and preferences. Where people required support with behavioural needs we found records were not detailed in providing support and guidance for staff. We discussed this with the registered manager who advised that reviews are ongoing with social workers. Senior staff have been actioned to carry out reviews of peoples care plans with them and their families to ensure that support and guidance for staff is up to date and relevant. We found the action plan in place with the local authority contained actions regarding care planning and that those actions were ongoing at the time of the inspection.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we identified a repeated breach of regulation 18, staffing. We found the meal time experience for people who used the service was inconsistent. We saw people did not always receive the dedicated support they needed from staff on duty. We recommended the provider look at the meal time experience and the environment for people living with dementia.

The provider had submitted an action plan setting out how they intended to rectify the breach in regulation 18, which stated that policies and procedures were to be reviewed, meetings would be held to discuss staff interaction with people during meals. Additionally picture menus were to be developed and sensory items were to be made available for people living with dementia.

We found some effort had been made to improve the environment for people who were living with dementia by adding sensory lights to one lounge. No other areas within the home had been developed in terms of being dementia friendly. Picture menu cards were now available for people.

We found the provider had not reviewed the policies and procedures in line with their action plan.

Following concerns raised in respect of staff's ability to manage behaviours that may challenge we looked at staff training, supervision and appraisal as part of this inspection.

The registered manager provided us with a training matrix. We found staff training was not up to date. Staff had not received training to enable them to meet the needs of people who may present with behaviours that challenge.

Out of 17 care staff, 11 had completed dementia training. Of the 11 staff who completed dementia training, 9 had completed the training five years ago. This meant we could not be sure staff were aware of up to date guidance and best practice when supporting people living with a dementia. Only two had completed falls training, only six had completed food hygiene. Only the registered manager had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training (MCA/DoLS). The provider did not have mental health training or challenging behaviour on their training matrix despite supporting people who were living with mental health needs who demonstrated behaviours that may challenge.

We found supervision had been carried out regularly, however not in line with the provider's policy of six per year. For example one staff member had not had supervision since December 2016 but had had an appraisal in February. Another had received supervisions up to February 2017 but no other supervision had taken place. We found the registered manager kept a list of staff names against months of the year for supervisions in 2016. It was not clear if these had taken place. There was no list in place 2017.

This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Staffing.

We discussed the lack of MCA/DoLs training with the registered manager who advised that training in this had been planned with South Tyneside Council. They showed us a leaflet from a training agency with details of courses for challenging behaviour. The registered manager advised they were looking to book places for staff. No timescales were in place for this action.

We carried out a SOFI over lunch time to observe the experience of people. Tables were laid prior to people taking a seat. We found an appropriate level of staff members supporting people with their food and drink. Picture menu cards were available for people. Alternatives were provided for people when they did not want the menu option. We found there was some TV noise from the conservatory spilling in to the dining room. The cleaner was vacuuming in the hallway and encroached slightly in to the dining room. We felt this could have been timed better so as not to cause unnecessary noise during the meal. Although staff did interact with people when serving meals and used appropriate communication techniques speaking at eye level. We felt there were opportunities for more ad hoc interaction between specific tasks. During our observation we found the atmosphere relatively neutral during the meal.

We had received concerns that staff were getting people up between 4am and 7am and left without fluids or access to fluids. We arrived at the home at 5am and found people were still in bed. One person was up; on speaking to them this was their choice. They told us, "I like to be up early and once it gets to six, that's me wanting to be up." We asked if they were offered a drink once they were up. The person confirmed staff always offered a hot or cold drink.

We found positive relationships between people and staff. Staff knew people well and were able to describe the care and support they provided. For example, how people wanted to be supported with personal care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we identified a repeated breach of regulation 17, good governance. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided.

The provider had submitted an action plan setting out how they intended to rectify the breach in regulation 17, which stated health and safety audits would be in place. A new suggestion book in place for the provider to make comments would be made available. Regular audits of the service, staff supervision and appraisals were to be carried out and regular staff meetings were to take place.

A suggestion book had been made available for the provider to make comments when they visited. We saw the provider had used the book to make general comments about the home. The suggestion book contained brief statements we did not find any detailed recommendations or actions to drive improvements.

At this inspection we found that several audits had been completed. For example, fire alarms, door releases and fire extinguishers. Room audits were completed covering cleanliness, fixtures and fittings. An annual health and safety audit was completed by the registered manager. We found that although the provider had implemented an audit process and schedule we were not assured of its effectiveness as it had failed to proactively identify the concerns and issues we found at this inspection.

Supervision records showed some had taken place but not at the frequency stated in the provider's policy. The registered manger did not have an annual plan in place for supervisions for 2017. Some appraisals had taken place for 2017.

We found issues with record keeping and storage of records. Staff used a blue file kept on top of a storage unit in the dining room which held several documents pertaining to people's care needs. This meant that people's personal care records were not being stored securely. The file contained documents named 'personal hygiene charts'. We found these were task focused with boxes to tick if someone had had a bath, shower, fingernails done, glasses on and teeth/dentures in. Food and fluid charts were in place for people who required their intake monitoring, we found these were not totalled or reviewed to ascertain if the person had sufficient intake and hydration. Output charts for one person who had an indwelling catheter did not have a 24 hour total recorded. This meant the provider was using an inappropriate method of recording people's personal support needs. The process of monitoring nutritional intake was not effective or robust in that we found no oversight or analysis from staff.

These findings show the provider's quality assurance process was not effective in identifying shortfalls.

This was a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Good governance.

Regular staff meetings had taken place. Staff felt they could speak to the registered manager if they had any concerns and found them to be open and supportive.

Despite our findings and identified shortfalls, people and relatives were positive about the care home. One person told us, "It's nice here, look [pointing at a care worker] how lovely she is." Another said, "Oh I am alright, have everything I need." Comment from relatives included, "[Family member] is a different person since being here, the staff have been amazing", "We are involved in reviews, they [staff] go through he file with us" and "I come twice a day, I wouldn't have [family member] anywhere else and the girls are great.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not fully assessed the risks to the health and safety of people who use the service. Risk assessments did not contain detailed guidance for staff. Policies and procedures had not been reviewed. Regulation 12 (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had appropriate training and supervision necessary to enable them to carry to carry out their duties. Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (2)(a)

The enforcement action we took:

We served a warning notice against Regulation 17 good governance.