Optima Care Limited

Seahaven

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Seahaven is a residential care home providing personal care to up to 19 people who have a learning disability and or autism. The service was delivered in 2 adjoining houses, registered as a single location. At the time of our inspection, one house accommodated 11 people and 6 people lived in the other. Most people who used the service received support with personal care. This is help with tasks related to personal hygiene and eating. Where people receive this support, we also consider any wider social care provided.

People's experience of using this service and what we found

Right Support:
Risks to people were identified and there was full guidance in place to mitigate the risks. However, staff did not always follow the guidance and failed to report to management when incidents occurred. This meant that appropriate actions were not taken to mitigate the risks.

Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome. However, when people were prescribed 'as and when' medicines for when they were distressed there was no guidance in place to make sure these medicines were given consistently and safely. At night there were times when people might have to wait to receive their 'as and when' medicines as not all staff were trained to administer medicines.

People were supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were recruited safely and there was enough staff deployed to ensure people received the care and support they needed when they needed it.

People were assisted to achieve their aspirations and goals. Staff focused on people's strengths and abilities to learn and develop new skills. People pursued their chosen interests.

Right Culture:

Quality assurance systems were in place to monitor the service people received. However, they had not identified the shortfalls we found at this inspection regarding risk assessments and medicines.

People led inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff. Staff placed people's wishes, needs and rights at the heart of everything they did. The stable management and core staff team supported people to receive consistent care from staff who knew them well. People received compassionate and empowering care which was tailored to their needs. People and those important to them, were involved in planning their care. People's relatives felt that there was good communication, and they were kept informed of any changes to people's wellbeing.

Staff evaluated the quality of support provided to people, involving the person, their families and other professionals as appropriate. All the relative we had contact with were complimentary and positive about the service and the care and support their loved ones received.

Right Care
People were treated with kindness and care. Staff showed genuine affection in their approach. Staff knew people well. Day to day choices were offered to people and staff demonstrated a good understanding of people. Some people were not always encouraged to take an active role with tasks such as making meals and helping around the service. At times staff did things for people and not with them. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs.

Staff understood how to protect people from poor care and abuse. People indicated and said they felt safe living at Seahaven. We observed people to be relaxed in the company of staff. Safeguarding concerns had been responded to promptly. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

People's care, treatment and support promoted their wellbeing and enjoyment of life.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 May 2021) and there were breaches of regulation. We served the provider with 3 Warning Notice under Section 29 of the Health and Social Care Act and 2 breaches of the regulations.

We undertook a targeted inspection (published 10 January 2022) to check the provider had taken action against the Warning Notices. The provider had taken action and the warning notices had been met. This did not change the previous rating of requires improvement because we only looked at part of the key questions. There were still 2 outstanding breaches of the regulations.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced inspection of this service on 11 March 2021. Breaches of legal requirements

were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve fit and proper persons employed, and notifications of other incidents.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

This inspection was prompted by a review of the information we held about this service and to follow up on action we told the provider to take at the last inspection.

The inspection was also prompted in part due to concerns received about safeguarding incidents. A decision was made for us to inspect and examine those risks. We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains the same. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Seahaven on our website at www.cqc.org.uk.

Enforcement
We will continue to monitor the service and will take further action if needed. We have identified a breach in relation to safe care and treatment and in relation to governance and oversight.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Seahaven

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Seahaven is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Seahaven is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The provider was in the process of recruiting a new manager who was going to apply for registration.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated verbally and nonverbally with 4 people. We spoke with 7 members of staff including, the deputy managers, locality manager, managing director and 3 support workers. We looked at 3 people's care plans and risk assessments. We looked at a range of other records including accidents and incidents, 3 staff recruitment files, medicines records, and audits. We looked staff rotas, minutes of staff and residents' meetings and quality assurance.

After the inspection we spoke with 2 relatives and sought feedback from visiting professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the inspection on 11 March 2021 this key question was rated as requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At the inspection in March 2021 the provider had failed to ensure that staff had been safely recruited and had not ensured recruitment procedures were operated effectively. This was a breach of regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed.

At this inspection improvements had been made and the provider was no longer in breach this regulation.

● Staff recruitment and induction training processes promoted safety, including those for agency staff. Staff knew how to take into account people's individual needs, wishes and goals. People were supported by staff who had been safely recruited. References were obtained to ensure staff were of good character and safe to work with people. People were involved in the recruitment process and met potential new staff.
● Criminal record checks with the Disclosure and Barring Service (DBS) were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. People were supported by a regular staff team who knew people well. The deputy manager monitored the one-to-one hours people needed to ensure there were safe staffing levels.
● Throughout the inspection there were enough staff available when people needed support. The service used regular agency staff, who had got to know people well, whilst they were actively recruiting for permanent staff.

Assessing risk, safety monitoring and management
● Risks to people were identified and recorded. We found that when risks had occurred, they had not been reported to management and action had not been taken to make sure people were safe. There was guidance for staff on the action to take to prevent the risk occurring and what to do if it did occur.
● Records showed that action had not been taken by staff when a person was at risk due to significant weight loss. This had not been reported to management and action had not been taken to investigate this further. We discussed this with the deputy manager during the inspection. The person was re-weighed and it was found the recording was inaccurate, and the person had not lost weight.
● Staff were not always following risk assessment guidance. For example, a person who was diabetic had their blood sugars monitored throughout the day. We found that on occasions their blood sugars exceeded the recommended level recorded in their risk assessment for a period of over 24 hours. Staff had not

reported this to management and no action had been taken to seek medical advice. There was risk the persons condition could have become unstable and they could become unwell. The deputy manager told us immediate action would be taken to prevent re-occurrence.

The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that is reasonably practicable to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental and fire risks were managed well. The environment and equipment was safe. Checks were made regularly to identify any shortfalls or issues. Action was taken to minimise any risks.

Using medicines safely

● People received their routine daily medicines as they were prescribed by their doctor. However, when people needed 'as and when' medicines for when they were upset and distressed, we found there was no guidance for staff to explain to them at what point the medicine should be given. There was no guidance on how often to take the medicine and what action to take if the medicines had not been effective. There was a risk that people would receive these medicines inconsistently and not in line with prescribing instructions.
● We found on some night's duties staff were not trained to give medicines. This did not impact on routine medicines, however, if people needed their 'as and when' medicines during the night there was a risk staff would not be able to give the medicines and people would have to wait until an 'on call' member of staff could be contacted and arrive at the service. The provider was taking action to train more staff to give medicines.
● We found a medicine that require special storage had not been returned to the pharmacy. The medicine had been discontinued many months ago. Royal Pharmaceutical guidance states medicines which are not being used should be returned to the pharmacy as soon as possible.

The provider had failed to ensure the proper and safe management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both). Some people's medicines had reduced significantly since living at Seahaven.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse, harm and neglect. Staff knew people well and understood how to protect them from abuse. The staff worked well with other agencies to do so. If safeguarding concerns were identified, they were reported to the local county council safeguarding team. Investigations were completed and appropriate action was taken to prevent them occurring in the future.
● Staff had training on how to recognise and report abuse and they knew how to apply it. Staff told us they would not hesitate to report any concerns to the deputy manager or locality manager. They were confident action would be taken. They also knew who to report concerns to externally.
● People appeared relaxed and confident in the company of staff and relatives told us they felt their loved ones were safe. Relatives described how the service kept people safe without restricting their independence A relative told us, "My [person] is always happy to go back to Seahaven after they come to visit. That has to be a good sign."

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● The management team had a good understanding of the Act and was working within the principles of the MCA. People were not unduly restricted and consent to care and treatment was routinely sought by staff.
● Staff understood when a DoLS application should be made and the process of submitting one.

Preventing and controlling infection
● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keep premises clean and hygienic.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Visitors were welcome and there were no restrictions.

Learning lessons when things go wrong
●There was a culture of learning when things had gone wrong. The management team had reflected on past situations when they could have acted differently. They described the things they had learned and put in place to help minimise the same happening again.
● The provider recently investigated concerns that had been received by the CQC. The investigation was thorough and detailed. Action was taken to address shortfalls that were identified. Information was shared with staff. The provider recognised shortfalls and was in the process of addressing these.
● Staff knew how to respond to and report any accidents and incidents. The way this was done had recently been reviewed to make sure information was accurate and staff were reporting consistently. All significant events were reviewed and analysed by the management team. Any patterns or trends were identified, and action taken to reduce the chance of the same things reoccurring.
● Relatives told us, they were informed of any incidents that occurred involving their loved one. A relative said, "The staff always keep me up to date about what is happening. If any incident occurs, they explain how they will try and stop it happening again. I feel involved."

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the inspection on 11 March 2021 this key question was rated as requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the inspection in March 2021 the provider had failed to notify the CQC of notifiable incidents. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection improvements had been made and the provider was no longer in breach this regulation.

- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The management team was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.
- The deputy manager understood their responsibilities under the duty of candour when incidents occurred. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The deputy manager kept families informed of any concerns with their loved one.
- When things had gone wrong the management team and staff were open and honest. Investigations took place and action was taken to make improvements and prevent any re-occurrence.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of the inspection the service did not have a registered manager in post. The previous registered manager had recently left the service. The provider was in the process of recruiting a new manager and the recruitment process had begun. In the meantime, the deputy manager was managing the service on a day to day basis. They were supported 3 days a week by the locality manager and the managing director frequently visited the service.
- Management quality assurance checks of key areas of the service had been completed but they had not identified the shortfalls found at this inspection. Quality assurance audits had not identified that action had not been taken when potential risks had occurred. It had not been identified that there were shortfalls in the safe management of medicines. Some care plans had not been reviewed and updated.

The provider had failed to fully monitor and mitigate the risks relating to the health, safety and welfare of service users. This is a breach of regulation 17 of the Health and Social Care Act 2008(Regulated Activities)

Regulations 2014.

● Other quality assurance checks and audits had identified areas that needed improvement, for example, environmental improvements, communication between the staff team and further training for staff. There was an action plan in place to address these shortfalls.
● The deputy manager had a good understanding of the risks at the service and understood why it was important to analyse incidents to prevent repeated occurrences. There was learning to try and improve the standard of care people were receiving.
● People said and indicated they were happy and contented with the care and support they received from management and staff. People and relatives spoke highly of the staff team. A relative said, "We get on well with the staff team. I have great trust and respect for the work they do. We are treated like members of the family." Staff were clear about their role and were positive about the management team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The management team and staff understood the aims and values of the service to provide personalised care and support, and this was the culture amongst the staff team. People were the priority and at the heart of the service.
●Some people were supported to do things for themselves and live fulfilling and active lives within Seahaven and in their local area. We did find that sometimes staff did things for people when they could have done activities with them. For example, staff washed people's clothes and put them away. People were not encouraged and supported to do this. This in an area for improvement.
● Other health care professionals provided positive feedback about the culture and staff approach at the service. A visiting professional told us, "I tend to spend some time at the home and have lunch with people. It gives me a greater opportunity to see interactions between staff and residents and how they manage daily routine. This has always been a positive experience."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team promoted equality and diversity in all aspects of running the service. People's individual needs were identified and respected. People were communicated with in ways they understood and suited them best. People had a voice, and their views were listened to and acted on.
● People, and those important to them, worked with the staff to develop and improve the service. The deputy manager sought feedback from people and those important to them to help to develop the service. Following the inspection people had been supported to take part in in a 'house' meeting, where people and staff discussed the inspection. People also made suggestions about activities, menus and improvements to the house. Further regular meetings had been planned. Relatives told us they were regularly asked for feedback and suggestions.
● Staff told us they had supervisions with a member of the management team, and they felt the supported in their role. Regular staff meetings were held where staff could discuss issues and ideas.

Continuous learning and improving care; Working in partnership with others
● The management team were clear about the further improvements needed in the service and the staff were supportive and actively involved in making the improvements.
● Staff and relatives told us the management team were approachable and took a genuine interest in what people, staff, family, and professionals had to say
● Staff felt their ideas and feedback were listened to and acted upon. One staff said, "The management team are very supportive."

● The provider demonstrated they were working in partnership with others to meet people's needs and help them achieve their outcomes. The deputy manager and staff team had good working relationships with the local authority and local healthcare professionals including GPs and community nurses.
● Health care professions and partnership agencies provided feedback showing the partnership working with staff. A visiting professional said, "The staff have a close relationship with the doctor's surgery/health team who make weekly calls. Their GP sees people face-to-face as and when needed. This service was the only home that I am that I am aware of that used dummy injections to help with desensitization in preparation for the Covid -19 injections which led to positive outcomes."

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 failed to assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that is reasonably practicable to mitigate any such risks. The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to fully monitor and mitigate the risks relating to the health, safety and welfare of service users.