The Seymour Home Limited

Seymour Care Home

Inspection report

327 North Road
Clayton
Manchester
Greater Manchester
M11 4NY

Tel: 01612208688
Website: www.theseymourhome.co.uk

Date of inspection visit:
30 October 2017
31 October 2017

Date of publication:
21 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 30 and 31 October 2017. The inspection was prompted in part following information of serious concern received from two whistle-blowers. The whistle-blower alleged physical, psychological and emotional abuse to seven people living at the home. Whistleblowing is when a person tells someone they have concerns about the service they work for.

We last inspected Seymour Care Home on 26 September 2016 when we rated the home 'Requires Improvement' overall. At that inspection we found a breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Need for consent. We issued a requirement notice to the provider to formally inform them of the reasons they were in breach of the regulations and to tell them improvements must be made.

At this inspection we identified ongoing concerns and breaches of the regulations. We found breaches of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, person centred care, good governance, recruitment, training and premises and equipment.

You can see what action we have told the provider to take at the back of the full version of this report. We are currently considering our options in relation to enforcement and will update this section once any enforcement action has concluded. As a result of our concerns, we requested and received an urgent action plan from the provider that detailed the immediate actions they would take ensure the safety of people living at the home. Furthermore, Manchester City Council Commissioning team have temporarily suspended all new admissions to Seymour Care Home until further notice.

Seymour care home is situated in the Clayton area of Manchester and provides residential care for up to 27 people. The vast majority of people are living with dementia. Accommodation is based over two floors and there is a passenger lift between the floors. At the time of our inspection there were 24 people living at the home.

At the time of our inspection the service had a registered manager. 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.

We looked at the concerns raised and found the provider had not protected people from the risk of harm and abuse as some people were being unlawfully restrained as a means of managing their behaviour.

People within the service were not always safe. It was standard practice for sluice and laundry rooms in the home to be left unlocked, placing people at risk of harm by potentially coming into contact with hazardous

materials. On the first day we noted a hoist had been stored on the ground floor corridor; this posed a potential trip hazard. We found no evidence to show the home's passenger lift had been examined to ensure it was safe to use under the 'Lifting Operations and Lifting Equipment Regulations' 1998 (LOLER) .

People's medicines were not being managed effectively and we found a number of shortfalls. For example, we found the clinic room was warm and no room temperature recordings had been completed. The provider could not be assured medicines stored in the clinic room had not been compromised due to fluctuating room temperatures. We found that practices around administering medicines were also not robust and not safe and important information about people's medicines was missing. People were in danger of not receiving the right dose of the right medicine at the right time, as prescribed.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to people's needs.

There was a lack of leadership and governance at the home and effective systems to seek feedback of the experience of people was not in place. There was a lack of support and coaching for staff and this was reflected in the care they provided. Auditing systems were not robust enough to ensure that the service was compliant with the Health and Social Care Act 2008 and as a result these had not identified the concerns that we found during our inspection. Where audits had identified improvements that were required, these had not always been actioned. The provider had also failed to notify CQC of important incidents and events.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed. This impacted on people's well-being and they were at high risk of receiving inappropriate care that did not meet their needs and reflect their preferences.

The culture within the home did not promote a holistic approach to people's care to ensure that their physical, mental and emotional needs were being met. Care plans were incomplete, inconsistent and task led. We found two care plans had not been updated to reflect people's current care needs. Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference.

Staff had received a training session on the Mental Capacity Act 2005 (MCA), however the staff we spoke with had limited understanding of this legislation. As a result we found care plans failed to address people's abilities to make decisions about care and support, or evidence where decisions had been made in a person's best interest.

Complaints were not clearly recorded and did not provide assurances that people's complaints were responded to appropriately.

There was not an effective system in place to ensure there were sufficient numbers of staff on duty to support people and meet their needs. There were not enough staff to provide adequate supervision, nutritional support, stimulation and meaningful activity. This had a direct impact on people's safety and welfare.

Staff received supervision and appraisals. Staff told us the training they received was good, however a course intended to enable staff to help people manage their behaviours had not been reviewed in over five years. This led to staff not having the confidence or skills to support people safely when people's behaviours

challenged others.

Staff reported accidents and incidents to the office however; the management team did not always review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again.

The home environment was not dementia-friendly, in that adjustments had not been made to help people living with the condition to maintain their independence and navigate around the home. We recommend that the home investigates and implements good practice in modern dementia care to improve people's quality of life.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration, the service will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a lack of safe medicine management processes in place. Important information about people's medicines was missing.

Risk assessments did not meet people's needs safely placing people at risk from potential harm.

There were not enough staff to safely meet the needs of people. Staffing levels were not set according to people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, however their understanding of the principles was limited. Assessments did not demonstrate that staff had assessed people's capacity to make a decisions or whether they were acting in their best interests.

Staff had received training and supervision to enable them to develop further skills and knowledge. However, staff had not received specialist training in managing behaviours that challenges others in over five years.

Is the service caring?

Requires Improvement

The service was not always caring.

The privacy and dignity of people in receipt of end of life was not respected.

The basic principles of equality, diversity and human rights were not understood or embedded in the home.

People were not always involved in planning their care or supported to make choices relevant to their needs.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not sufficiently detailed and did not give the staff the information they needed to care for people in the way they liked.

There was no auditing system in place for monitoring complaints to identify trends and patterns.

There was a lack of meaningful activities.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and governance at the home. The provider did not have oversight of the service. There was not a positive culture within the service to ensure the delivery of person-centred care.

The provider had not reported safeguarding incidents to the Care Quality Commission.

Systems to ensure the provider had an oversight of the quality of the service were not effective.

Seymour 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 and 31 October 2017 and the first day was unannounced. The inspection was carried out by three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had personal experience of services for people living with dementia.

Prior to visiting the service we attended a multi-agency strategy meeting with Manchester City Council Commissioners, Manchester Safeguarding team and Greater Manchester Police. It was confirmed at this meeting allegations had been made against a staff member at Seymour Care Home, which resulted in the staff member's suspension. Manchester City Council advised they had made an announced visit into the home on the evening of 14 October 2017. No 'overt' issues were found at that time.

We contacted Manchester City Council's Commissioning teams and Manchester safeguarding team for information they held on the service. We also contacted Manchester Healthwatch. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services. The information we received helped us to plan our inspection.

The provider completed a Provider Information Return (PIR) in September 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed information we held about the service, including the provider's PIR and notifications the provider had sent us about safeguarding and other significant events. We also looked at any feedback we had received about the service.

During our visit we spoke with the nominated individual, registered manager, deputy manager, three care assistants, a domestic, 13 people who lived at the home and five relatives. We looked around the building,

including all communal areas, toilets, bathrooms, the kitchen, and some peoples bedrooms (with their permission). We looked at the systems and processes in place for monitoring and assessing the quality of the service provided by Seymour Care Home and reviewed a range of records relating to the management of the service including: five care plans; three staff files; staff training investigatory records; rotas; medication; maintenance and audit documents.

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.

Inadequate

Is the service safe?

Our findings

The provider failed to ensure that people were protected from abuse and improper treatment. Prior to the inspection we received information of concern relating to the unlawful use of restraint on people. During the inspection we found evidence to support the allegations that an illegal restraint had been used and as a result of our findings we made safeguarding referrals to the relevant authorities.

People we spoke with told us they felt safe. Staff we spoke with demonstrated a clear understanding of safeguarding and were able to describe signs of abuse and the procedures to report any concerns they might have about people's wellbeing. However, we found safeguarding procedures were not always effectively operated. We were notified by two whistle-blowers of concerns in relation to staff working at the home. One of the concerns was in relation to a staff member who was dismissed in November 2016. The allegation made stated the dismissed member of staff purposefully tied a person's bedroom door closed with a dressing gown belt which was then attached to a bench located outside the person's bedroom during the night. We discussed this serious incident with the registered manager who confirmed this had happened. The registered manager told us the incident was considered to be a health and safety issue rather than a safeguarding matter. However, we viewed the registered manager's investigatory notes which indicated this could have been perceived as abuse. Three staff statements we saw confirmed the staff member locked the person in their bedroom. This practice purposely restricted the person's movements within the home to her bedroom and placed the persons health and safety at risk. The provider failed to disclose this information about the staff member's conduct when reporting to Disclosure and Barring service (DBS) and failed to notify the local authority safeguarding team. Subsequently the Care Quality Commission (CQC) has made a referral to DBS to ensure this staff member's conduct was reflected on any future disclosures. At the time of this inspection this matter was still with Manchester City Councils safeguarding team.

We were also informed of a second incident prior to our inspection by the whistle-blower concerning another staff member. Allegations suggested the member of staff was showering and bathing people in a manner which was described as 'like a conveyor belt.' It was alleged that the staff member was carrying out personal care in an inappropriate and undignified way as people were being lined up in a state of undress in front of each other both before and after having a shower. The deputy manager informed us they had been approached by a member of staff who had concerns about the way their colleague was supporting multiple people with their personal care needs. The deputy manager told us they stayed back to observe the staff member's practice and confirmed they were shocked at the poor observations they witnessed. The deputy manager commented that they observed the staff member supporting three people in quick succession with their personal care needs. The deputy manager said people were dressed after their personal care, but they did not have their dressing gowns on and felt this was not dignified for the people. The deputy manager intervened by stopping the staff member with the rushed manner they were completing personal care tasks. The deputy manager confirmed during the inspection they had also notified the registered manager of the staff member's conduct, and was surprised the registered manager had not taken any action against the staff member in question.

The registered manager said they had investigated the matter and no further action was necessary. This matter had not been reported by the registered manager to Manchester City Council safeguarding team, therefore the CQC notified the safeguarding authority of these concerns. The registered manager confirmed this incident did take place and the member of staff has now been suspended pending investigation.

In both instances, the provider had failed to make safeguarding referrals to the local authority and CQC had not been notified. This demonstrates that procedures for investigating and acting upon potential safeguarding concerns were not operated efficiently to ensure the safety and wellbeing of people living at the home.

This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed and administered safely. The service had a locked treatment room where the medicine trolley was securely stored. The medicine's fridge temperature had been recorded daily to ensure medicines were stored at the correct temperature to maintain their efficacy. However, we found the clinic room was warm and no room temperature recordings had been completed. Room temperature monitoring must take place on a daily basis (preferably at the same time each day) and the actual, maximum and minimum temperature should be recorded to ensure the storage of medicines temperature doesn't exceed 25°C and that medicines are not spoilt. We found a thermometer in the clinic room which indicated the room's temperature was 26°C. If the temperature of the medication room reaches above 25°C for more than seven consecutive days, then a significant event form should be completed. We found this had not been undertaken by the provider. We found the provider had not considered whether the room temperature had impacted on any of the medicines stored and no action, such as the introduction of an air conditioner in an attempt to control the problem had been taken. As room temperatures had not been recorded on a daily basis this meant the provider could not be assured the medicines stored in the clinic room had not been compromised. This could have an impact on people's health and wellbeing.

We saw every person had a profile sheet in the medicines folder, which should include a recent photo and details of any allergies. We found the provider adopted an inconsistent approach with many profiles not fully completed. There was a risk in relation to this discrepancy as care workers who administered people's medicines did not have these safeguards in place to ensure people safely received their medicines as prescribed. A list of staff responsible for administering medicines, together with sample signatures was not available for reference. The importance of having a list of staff responsible for administering medicines is not only good practice, but it also indicates to people living at the home staff who are qualified to administer medicines and provides an audit trail for assurance purposes.

We observed the medicine round during the first day of our inspection and found that the practice was not safe. We observed that the senior care worker prepared the medication in the clinic room and then handed this to another care worker for them to distribute the medicines to the person. The senior care worker would then sign the Medication Administration Record (MAR) to indicate the medicines had been seen to be taken and safely administered. We told the senior care worker that this method was not safe as the care worker giving the medicines did not have the container with the label and cannot be assured that each person has received the right dose of the right medicine at the right time, as prescribed. In addition the senior worker is making a false record because they have not actually seen or evidenced the person taking the medication and this practice could result in serious errors. This process removes a vital safety-net to check the medicine, strength and dose with the MAR chart and label on the medicine at the same time you check the identity of the person. We provided this feedback to the registered manager while we were at the service.

We also received concerns from one person's family member about their family member's medication, after finding tablets in the person's bedroom. Their comments included: "We found some tablets in a drawer. My mum had clearly spat them out and hidden them. We told the staff now watch mum to make sure she swallows them."

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) Protocols give direction to staff as to how and when these medications should be administered as they are not routine. This meant that staff may not be aware when a person needed medicine, such as pain relief, because there was no guidance to show how people communicated that they were in pain when they were unable to verbalise how they were feeling. For example, we found one person was prescribed Codeine Phosphate for pain relief, however there were no PRN protocols in place to detail why the person required this pain relief or when they might need it.

Staff had received training in medicines. However, records did not evidence that staff had, had their competency checked. We were informed by the registered manager that staff were shadowed to monitor competency levels but that these assessments of competency were not recorded. The registered manager informed us that they would start to record medication competencies for the staff who administer medicines. This meant that the provider could not evidence that staff administering medicines were competent to do so.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. A monitored dosage system was used for most of the medicines with others supplied in boxes or bottles. Monitored dosage systems consist of blister packs made up by a pharmacist, where the tablets each person takes at different times of the day are supplied in separate sealed pots. We checked the medication administration records (MAR) and saw that there were no gaps, and it was clearly recorded when people had refused to take their medicines or had not required it. Given our earlier observations and findings however, we could not be assured that these records were accurate.

We checked the storage and management of controlled drugs; controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation and include medication such as morphine. We checked the stock of controlled drugs and found inconsistencies with the recording of controlled drugs. For example, we found on occasions the controlled drug medication book had not been signed for by two members of care staff, in line with best practice guidelines. Controlled drugs should be administered by appropriately trained and competent care staff, and this should be witnessed by another appropriately trained care staff member. The use of a witness is intended to reduce the possibility of an error occurring and to minimise their misuse, therefore to be effective the witness must have the same level of training as the person administering the controlled drug.

Additionally four of the controlled drugs in the medication cabinet for one person did not tally with the amount recorded in the control drugs log book. We were told by the senior care worker this medication is solely administered by visiting community nurses who keep their own records. During the second day the registered manager provided copies of the community nurses control drugs records which indicated the balance of medicines were now accounted for and the issue was with the home not ensuring their controlled drug book was being updated after these medicines were administered.

We found the provider did not have a safe operating procedure in place for stock checks of all controlled drugs entered into the controlled drugs register. This meant the provider could not satisfy the balance of controlled drugs register matched against the current stock to ensure people's medicines were safely managed.

Where people were prescribed topical creams and lotions we found that there was no body maps to inform staff where the creams needed to be applied. This meant we could not determine if people had received theses medicines as prescribed.

All of the above constitutes a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.

During our tour of the home we noted potential safety hazards which did not keep people safe from risks relating to the environment. Doors to some rooms, including those containing potentially hazardous material or equipment, were left unlocked. For example, sluice and laundry rooms. A stationary cupboard had a bucket of cleaning products in it. All these rooms had locks on them, but were left open. People living in the home had the opportunity to walk around the building and potentially access these areas, so placing them at risk. On the first day we noted a hoist had
been stored in the ground floor corridor; this also posed as a potential trip hazard.

We brought these concerns to the register manager's attention during the inspection. We found these above areas were addressed during the second day of our inspection.

The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monthly safety checks and audits were being carried out to ensure people were protected from the risk of unsafe care and treatment. For example we saw appropriate checks were done in relation to fire alarms, fire extinguishers and emergency lighting. However, there was no evidence to show that the passenger lift had been examined to ensure it was safe to use. The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) introduced requirements for the safe provision and use of lifting equipment. Regulation 9 of LOLER requires that all lifts provided for use in work activities are thoroughly examined by a competent person at regular intervals. The passenger lift must receive a thorough examination at least every six months if the lift is used at any time to carry people. We were provided with evidence the passenger lift had received a number of call out visit's from a passenger lift company, however this documentation did not provide assurances the passenger lift received an examination in respect of LOLER.

Shortly after the inspection the provider contacted us to say the passenger lift examination had taken place on 08/11/2017. The examination confirmed the lift was safe to use, but recommended works for the provider to consider. We will review the progress of this at our next inspection.

The provider had not taken reasonable steps to ensure the premises were safe. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire drills had been carried out and there was a business contingency plan in place to outline how people would be protected in the event of unplanned emergencies. During our tour of the home we noted many people's bedroom doors were being propped open by items of furniture, such as chairs. We discussed the potential fire safety risk and door closure systems with the registered manager who reported if a fire did break out staff would close the doors. We noted this specific guidance had not been recorded in the fire risk assessment or people's personal emergency evacuation plans (PEEPS) and in any event is unsafe.

We found PEEPS had been introduced for each person. However, we saw information for two people were still in place although one person had not been in the home for a number of weeks and the second person

had not been at the home for four days prior to our inspection. This left a risk of staff or emergency services not having the correct information they needed to safely evacuate people in the event of an emergency.

We have asked the Greater Manchester Fire and Rescue Service to advise the provider on fire safety arrangements in the home.

We reviewed five people's care files and found individual risks had been identified, including mobility, falls, nutrition and the use of bed rails. One person who displayed behaviours that challenge, with the potential to cause harm to others had no guidance recorded into their care plan and risk assessments. There was no information about what might trigger this person to be aggressive. This meant staff were not fully aware of the risks people could pose or how to mitigate those risks.

During our inspection we completed an observational walk-about of the home to establish who was being cared for in their bedrooms. In one bedroom we found a person sitting on a bed of another person's bedroom. Although the person who had walked uninvited into the bedroom was not causing a disturbance, they were at risk of being assaulted due to the person whose room they had entered as they were known to display behaviours that can cause harm to others. We informed the registered manager of this, who was not aware of this person's whereabouts within the home, as this had not been considered a risk by the home. We viewed the person's care plan and associated risk assessments and found no guidance had been provided to staff regarding how to safely support this person, while keeping other people and staff safe. This meant the provider had not ensured risks to people had been appropriately assessed to prevent and reduce the occurrence of harm to people.

People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks. This is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 24 people using the service when we inspected and accommodation was provided over two floors. The registered manager told us the usual staffing levels were one senior care worker and three care workers throughout the day and two care workers at night. These staffing levels were confirmed by the rotas we were provided with. An additional staff member was deployed as a cook. The registered manager, deputy manager, and housekeeper were also present during the day.
We found the provider did not use a staffing dependency tool to assess people's individual needs to calculate safe staffing levels within the home. Although staff we spoke with said there were enough staff working in the home, we were not assured there were always sufficient numbers of staff deployed to meet people's needs at all times. Staff we spoke with felt in general there were sufficient staff to meet the needs of the people who used the service. One member of care staff told us, "I believe we have enough staff on duty." We saw staff were generally on hand to attend to people's needs. However, we observed one person who used the service required close observation due to their behaviours, and two people were on the end of life care pathway. We were not assured the staffing levels were sufficient to meet people's needs and there was no evidence to show people's dependencies and the layout of the building had been taken into account to ensure staffing levels were safe.

On the first day of our inspection we arrived at 7am. We found 14 people were already up at this time and we were informed by the care staff on duty these people had chosen to get up at this time, however the care plans we viewed did not suggest they preferred to be up at this time. Due to the limited numbers of staff people could not have their breakfast until after 9am which meant that people waited for at least 2 hours to have their breakfast.

On the first day of inspection we also observed that one of the care assistants, who had been on duty the previous night, was now working in the kitchen.

We spoke with this member of staff who confirmed that despite working a night shift, they had gone home to get showered and changed and was now back to work in the kitchen. This practice was potentially unsafe. This was further evidence that insufficient numbers of staff were deployed.

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

We looked at the recruitment records for three staff members. We found recruitment practices were safe. Relevant checks had been completed before staff worked unsupervised at the home which included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in September 2016 we identified concerns in relation to the provider not ensuring mental capacity assessments had been completed for people who lacked capacity. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had still not made the necessary improvements in this area.

Records showed that a number of applications had been made to the local authority for people identified as potentially being deprived of their liberty. We checked four authorisations which had been granted to ensure that any conditions of authorisation were being complied with and found that they were. The registered manager had introduced a tracking sheet to monitor when applications had been made, whether there were any conditions on the authorisation and when the authorisations expired.

We found the registered manager adopted an inconsistent approach when it came to mental capacity assessments, as we found evidence this process had not been completed correctly in line with the mental capacity act. In all of the MCA assessments we reviewed, there was a lack of information which demonstrated how staff had sought to involve the person in the decision being made. This meant the provider could not be assured that due process was followed before a best interest meeting took place. We did not see a robust framework in place where best interests meetings were held, with a rationale for the decision being made, where the person was involved and who the main decision maker was and why. Best interest decisions had been taken and we could find no corresponding assessment prior to this stage which demonstrated that the person lacked capacity to make this decision for themselves.

Staff were unable to tell us about the MCA and how it applied to the people that they supported. The impact of this was significant because many of the people in the home were living with dementia. The staff team supported a number of people with complex needs relating to their dementia, who would be subject to a number of restrictions to keep them safe. We did observe instances where staff asked people's consent before providing care. This showed consideration to people's right to consent to day to day decisions. However, the provider did not have effective systems in place to ensure people's legal rights were maintained.

In all of the care plans we reviewed, no consent forms were on file to establish if people or their

representatives were in agreement with the care and treatment being provided. There was a lack of support provided to people which would evidence they had been involved in the planning and review of their care. People with capacity had not been given the opportunity to sign documents to evidence their consent to care and treatment. People without capacity had not been formally assessed for bed rails in use with best interest decisions made on their behalf by those qualified to do so. This meant that their human rights had not been considered. We spoke with the registered manager about this who told us they would be reviewing all consent forms in people's care plans, as they accepted they misunderstood the requirements of the MCA.

The lack of MCA assessments and not adhering to the principals and code of practice of the MCA was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014).

We looked at records of training and saw training had been provided in areas including safeguarding adults, moving and handling, infection control, fire safety, food hygiene, health and safety, first aid and dementia awareness. We found a number of these courses had been completed by the majority of the staff team. However we found staff last received training in challenging behaviour awareness in 2012, with some new staff not yet receiving this. We noted an incident during the inspection where we observed staff approach in dealing with a challenging incident and judged this had not been managed by staff with confidence. We discussed this area with the registered manager who confirmed they would be seeking refresher training for all staff in this area. We will review this at our next inspection.

New staff had been recruited and employed to work at the service since the last inspection. New staff completed an induction which was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. We saw on some staff files that they had completed this certificate. New staff spoken with confirmed they had undertaken an induction.

Staff had regular supervision and appraisals. Staff confirmed that they had the opportunity to meet with the registered manager on a regular basis. We saw from the records that the registered manager had a matrix in place to ensure that supervisions were undertaken regularly.

People were supported to maintain good health. Records showed that staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's needs. We saw that people had access to their GP, district nurses and other specialist such as audiology when this was required.

Seymour Care Home supports people who are living with dementia. However the décor of the home was not 'dementia friendly.' Doors were not painted in a colour to clearly differentiate them from the surrounding walls. People did not have pictures, their names or memory items on their bedroom doors to help them identify their own room. Some attempts to signage within the home had been made to assist people to know where they were in the home. There were some limited adaptations to make the environment more accessible to people living with dementia and refurbishment of the home's two lounges and the dining room had been completed.

We recommend the service reviews current guidance in relation to dementia friendly environments and incorporates dementia friendly adaptations. This should be done in consultation with people using the service.

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. This had been done wherever the person was; this included their own

home and other care settings such as respite centres or hospital. We looked at the pre-admission paperwork that had been completed for people currently living in the home and could see that the assessments had been completed.

Requires Improvement

Is the service caring?

Our findings

People we spoke with made positive comments about the staff and told us they were kind and caring. Comments included, "The staff are doing their best, I believe they are caring", "Caring is more than just a job", "They're (care staff) not too bad. They don't shout they don't call me bad names", "They're very kind and compassionate. Proper working people, looking after local working people."

The home is registered with the Six Steps end of life programme. This is a recognised system for supporting people at the end of their lives. Information about people's wishes in the event of their death had been recorded for some people, but not others. Where people had chosen not to be resuscitated in the event of a decline in their physical health, this information was clearly displayed at the front of their care records.

We looked at the homes approach to end of life care (EoLC) and found the service was engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who we are nearing the end of their life, could choose to remain at the home to be cared for in familiar surroundings by people they know and could trust. However, we found the ethos and values of the 'six steps' programme was not being adhered to. For example, people in receipt of EoLC were being cared for in their bedrooms but doors were wedged open with either items of furniture or commodes. This meant other people living at the home with a diagnosis of dementia, and who were mobile, were able to uninvited access peoples bedrooms. This was an intrusion to privacy and dignity and was not being monitored, at a time when a person nearing the end of their life should be cared for in a respectful way and in peaceful and calm surroundings. We also saw that for other people who were cared for in their own rooms, they experienced the same issue of having their bedroom door wedged open and people were able to freely enter their room.

We asked the registered manager how people's privacy was maintained in view of the use (CCTV) in communal areas that monitored and recorded people's actions and conversations. We asked the registered manager why they felt this was necessary. The registered manager said it was so they could 'check back on things'. The use of CCTV was not detailed in the service user guide to make people aware of its presence and there was no policy available on the use of CCTV and who had access to viewing the tapes. Furthermore, the registered person's had failed to consult relevant CQC guidance on the use of CCTV in regulated settings. This guidance is freely available on the CQC website.

This demonstrated that people's rights to privacy and dignity were not maintained at the home. This was therefore a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to dignity and respect.

Throughout our inspection visit, we observed how care and support was delivered in communal areas of the home. During these observations we found care staff had very little time to positively engage. For significant periods of the day, people lacked interaction that was not centred around task-based care. Staff we spoke with told us they would like to spend more time with individuals but the daily routine of the home meant this was not always possible. However, during the second day of our inspection, we did observe the deputy

manager comfort and support one person who had become very distressed and upset. Their interaction with this person was kind, warm and friendly which clearly had a positive impact.

People we spoke to could not recall whether they had been involved in planning their care needs. However, care records contained some personalised information which showed that people had been involved to some extent. For example, personal preferences around favourite foods was available, and in some instances information about preferred activities was recorded. People's family members we spoke with all confirmed that they had never seen their relative's care records, or been involved in the planning of their care. In situations where people do not have capacity to make decisions regarding their care needs and have a legally appointed deputy, it is important that this person is involved.

We looked to see how the home sought to promote the principles of equality, diversity and human rights (EDHR). Through the issues identified during this inspection, it was evident these basic fundamental principles were not embedded into everyday practice across the home.

Inadequate

Is the service responsive?

Our findings

There was a lack of clear guidance and key information for staff to enable them to support people with specific health conditions such as diabetes, epilepsy or arthritis. Therefore staff did not know the signs and symptoms to be aware of, or their relevance, to indicate a risk to the person's health, safety and wellbeing. This meant staff may not recognise the need to take action in order to prevent a person from becoming seriously unwell.

People's preferences in relation to their care, support with personal care and food preferences had been recorded. However we saw there were inconsistencies with care plans we saw and people's essential care needs were not recorded. For example, we found no care plans that included personalised details of the support people required for aspects such as living with dementia, epilepsy and diabetes. This meant that the correct level of support required by people was not assessed and documented so that care staff would understand how to meet their needs.

We reviewed five care files and saw they contained a range of information, including personal and social details, care plans and risk assessments. Risk assessments we viewed included those for falls, diabetes, pressure sores and epilepsy. However, where risks had been identified, we found that the control measures put in place were not always accurate or detailed enough. For example, we saw a risk assessment which stated a person had been diagnosed with diabetes. Although this had been identified we did not see a dedicated care plan which would have recorded the specific nutritional requirements to ensure this person's needs were met in a way that helped ensure their health, wellbeing and safety. In discussion with the deputy manager they felt this person's diabetes was still being managed correctly and provided evidence of health appointments specific to the person's diabetic care they had attended.

Staff did not always respond to people's changing needs. One person had been supported to a diabetic eye screening in September 2017, after which a number of recommendations were recorded from the consultant's letter. However due to this individual person not having a person centred diabetes care plan, this information had not been recorded so we could not be sure that their condition was being managed and their health could deteriorate. This placed the person at risk of missing vital health advice on how best to manage their condition due to the lack of guidance provided to staff on how best to manage the individual's condition. In discussion with the deputy manager they again commented that this was a recording issue and felt the person had been supported appropriately with their diabetes.

Daily care records were very task focussed and gave limited details about people's well-being, such as how the person was feeling. We found there was an inconsistent approach adopted by staff when completing daily notes. We found examples of no recordings for two people's daily notes we viewed during the night and we found daily notes never included the time when the daily log was completed. This meant information which may be vital to that person's wellbeing may not be highlighted to staff.

None of the care records we looked at contained a care plan that demonstrated how staff responded to individuals differing needs in terms of interests, social activities and meaningful interventions. We observed

people being left largely to their own devices on the days of our inspection, which resulted in an escalation in anxiety levels, distress and social isolation. There were limited resources available to assist in the delivery of meaningful activities throughout the day for people who were living with dementia, for example, using reminiscence activities or familiar daily tasks to encourage physical and mental stimulation.

Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference. Staff did not have the time to engage in activities with people to enhance their well-being. People who spent time in their bedrooms had little or no stimulation, only that from staff performing a care task. We observed that people were either very restless or withdrawn as they had little to occupy their time throughout the day.

We received mixed comments about the activities available, comments included: "I don't really do activities, not really. I play darts sometimes, in the 'Albany' our pub in the lounge", "There's bingo but they don't do it very often", "I watch TV, play bingo sometimes" and "As you can see not much going on here I'm afraid." Comments from people's relatives included: "They don't do anything really, however they do have a Christmas party", "I go to the films with my son and my husband", and "They play games, such as darts, skittles, indoor bowls, dominoes; they make cards for their families."

An activities co-ordinator had been recruited, but due to the staff shortages they were now working as a care worker. It was unclear how this support would be provided and how the management team planned to change the culture within the service to enable staff to provide a person centred approach to care that focussed on people's whole well-being. During the inspection the registered manager commented that due to the staff shortages activities had taken 'a knock' for the time being. We found the provider had not considered any timescales when activities would be fully resumed.

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

People and relatives said that they knew how to make a complaint, but not all were confident that issues would be fully resolved and addressed. We saw that four complaints had been formally raised since the last inspection. We found the registered manager's approach to dealing with complaints was inconsistent. We found with one complaint an investigation had taken place and a brief response provided for the complainant. However, we found for the other three complaints there was no follow up documentation to establish the outcome of these complaints, even though the provider's complaint log said they were closed. Furthermore, we found a staff complaint was also recorded in the log which should have been recorded as a disciplinary matter rather than a complaint. We did not see any evidence of the provider analysing and learning from these complaints to address the themes identified.

After the inspection the provider produced additional documents of how the home has responded to complaints. At the time of our inspection these documents had not been made available due to the inaccurate and poor recordings of complaints.

This meant the provider did not have effective systems in place to respond to complaints. This was a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Throughout the inspection visit we identified examples of poor practice amongst staff that demonstrated there was not a person-centred culture within the service. Staff lacked daily co-ordination and were under managed.For example, we found staff were not safely administrating medicines to people due to the way medicines had been prepared and we found care staff had very little time to positively engage with people.

Before the inspection we had received concerns from two staff members. The concerns raised were about the culture amongst staff, as well as the poor quality of care that people received. We asked staff about these concerns during the inspection but most staff we spoke with informed us they felt fully supported by the management team. However, two members of staff told us that they felt unsupported by management and we concluded from the inspection findings that there was a lack of leadership and management support in the service.

There was a lack of provider oversight and governance at the service which impacted negatively on the care that people received. We asked for clarity from the registered manager around roles and responsibilities of the registered provider, but did not get any assurances that there were clear lines of accountability within the management team. During the two days we inspected it was clear from a number of shortfalls identified at this inspection that the registered provider had no oversight or governance of the service. During the inspection we spoke with the nominated individual (registered provider) during a telephone call and established they spent the majority of their time overseas, which meant they did not have oversight of this service.

The owner of the home carried out infrequent 'compliance visit record checks' and made a record of their findings, with what action was needed to rectify any issues that had been identified. We saw the last visit was completed in June 2016. This visit looked at areas such as inspection of the premises and sampling of care records. However we found this audit / check had not considered aspects in relation to staff morale, the management of medicines and whether people and their relatives were satisfied with the home. We noted this compliance visit check had not picked up on any of the shortfalls we found during this inspection.

Seymour Care Home did not have systems in place to seek feedback from people using the service, their relatives and stakeholders and we found no resident's meetings had been arranged within the last 12 months. The registered manager said they had not got around to distributing surveys and felt residents meetings were previously not very well attended, but acknowledged this was an area for improvement. Surveys are a tool for improvement and should be used as such, however people were not consulted with about the service or provided with the opportunity to give feedback on the service.

The registered manager did not hold regular team meetings for the staff at the home and we did not see any minutes of previous meetings. The registered manager said that they preferred to address any issues with staff individually. Staff meetings are a valuable means of motivating staff and involving people in the running of a service; they are an ideal place to discuss incidents, encourage learning highlight good practice and help to promote the cohesiveness of the team.

There were no audit systems being completed in relation to falls, weight loss, pressure wounds, care plans or the environment. The registered manager told us that whilst information in relation to these areas was being collated, no analysis of this information was taking place to identify trends or patterns. We identified issues with the information contained within care records, which was not always up-to-date and meant that the service had little assurance that people were receiving the support they needed. We also identified hazards relating to the environment which had remained unaddressed at the time of the inspection visit, such as no examination for the passenger lift or risk assessments. This placed people's health and safety at risk. The registered manager told us that audits would be implemented and took immediate action to address specific concerns we had raised.

Staff did not show an understanding of the Mental Capacity Act 2005, or the lawful and safe use of restraint practices. People did not always consent to their care and treatment and we saw the use of both physical and mechanical restraints had been used within the documentation we viewed. For example, we found one person had been locked in their bedroom by a staff member who tied the person's bedroom door shut with a dressing gown belt to a bench located outside the person's bedroom. This incident was substantiated and meant the person had been unlawfully deprived of their liberty. The provider was not consistently following the principles of the Mental Capacity Act 2005 and was not ensuring people who lacked capacity to consent were provided with care that was least restrictive and in their best interests. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

We found medicines were not managed or administered safely. We saw that issues with a senior care workers competency and poor medication practices had been not been identified. Audits in relation to medicines did not identify shortfalls found during this inspection. People were at risk of not receiving their medicines as prescribed.

Quality assurance procedures did not effectively assess, monitor and mitigate risks to people including their health, safety and welfare. For example, where accidents and incidents were being recorded, no analysis had been undertaken to identify themes and recurring trends thereby limiting future occurrences. We found where quality assurance systems were in place they were ineffective. They had failed to identify the issues we found during the inspection and therefore failed to ensure that the service was compliant with the health and social are Act 2008.

The lack of clarity around the individual roles and responsibilities of the management team and the resulting lack of accountability meant the home was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the quality and safety of services provided were not assessed or monitored in order to identify any required improvements.

During the inspection we raised our concerns with both the registered manager and the provider and following the inspection we requested that urgent action was taken to mitigate the immediate concerns. The registered provider submitted an action plan that told us that remedial work was being undertaken. We referred the findings from this inspection to the local authority, Manchester City Council, who shortly after the inspection, temporarily suspended new admissions to the home.

It is a legal requirement that regulated services are operated and managed in an open and transparent way in relation to the care provided. As we have outlined in this report, the registered person's at Seymour Care Home failed in this regard. In particular, there were systemic failures to inform relatives and/or lawful representatives when significant allegations of a safeguarding nature were made; a failure to notify relevant persons such as the local authority and CQC and a failure to ensure that the complaints system took account of the duty of candour.

This was a breach of Regulation 20(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to duty of candour.

The registered provider is required by law to notify the CQC of specific events that have occurred within the service. We compared records that were being maintained by the registered provider with those on our system and found that this was not always being done. For example, we found two significant safeguarding concerns and neither had been notified to the local authority or CQC. This meant that the registered provider was not complying with the law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, because the registered provider had failed to notify where required.