Seymour House Residential Care Homes Limited

Seymour House

Inspection report

13-17 Rectory Road
Rickmansworth
Hertfordshire
WD3 1FH

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22 June 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Seymour House is a residential care home providing personal care to 45 people aged 65 and over at the time of the inspection. The service can support up to 50 people.

Seymour House accommodates up to 50 people across three separate floors, with shared washing facilities. On the ground floor there are three separate living and dining areas, an additional lounge, Kitchen and laundry room. The office is situated on the ground floor.

People's experience of using this service and what we found
People were put at harm and were at risk of harm due to lack of safeguarding processes and effective systems in place to identify risks for people. Care plans and risk assessment did not identify fundamental information to ensure people were supported in a safe way.

Staff lacked knowledge in what their responsibilities were under safeguarding processes and as a result people were exposed to continuous risk of harm, For example, staff were unable to identify when people needs health care input for people who are at risk of pressure sores. Staff skills were not assessed and there were gaps in training for staff. People were subjected to unjustified restrictions and the registered manager had not ensured they considered the legal requirements to do this.

When people's health needs changed staff were not equipped with the skills and confidence to know when health professionals needed to be referred to. We observed staff not being proactive in supporting people when they expressed, they were in pain or discomfort.

People were not always shown respect and dignity when being supported by staff and there was a lack of meaningful activities that people would enjoy. Some people's bedrooms were not decorated or personalised.

Infection prevention control measures were not effective, and practices meant that people were at risk of infections. Staff did not use safe practices when using personal protective equipment. There was equipment including hoists, standing stools, pressure relieving equipment that was not safe to use.

Quality assurance systems were not effective and did not identify the issues we found. We were not confident there was an open and honest culture in the home.

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

Rating at last inspection
The last rating for this service was good (published 19 April 2019).

Why we inspected
We received a safeguarding concerns in relating to how people were being supported with wound management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service and it was decided to not inspect any other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We found 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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people being harmed and at continuous risk of harm due to lack of processes and skilled staff. We identified a number of safeguarding concerns and the governance system was not robust to pick up where there were significant failings. The registered manager had not notified CQC where there were incidents of harm to people at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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 key 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Seymour House

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 Care Act 2014.

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 team consisted of two inspectors and one 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.

Service and service type
Seymour House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and 15 relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, assistant manager, care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with five professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were harmed and at risk of harm due to lack of effective safeguarding processes and systems in place for staff to follow to keep people safe from the risk of abuse. We found that staff were not always following processes and as a result a person had developed a grade two pressure sore. This was not picked up by the staff, but the health professionals conducting health and wellbeing checks.
- People were not always treated with respect and dignity. For example, a person had wet trousers. We observed staff cover the person with a blanket and continue to encourage them to participate in chair exercises. It was not until the inspector intervened by speaking with the registered manager that the person was supported.
- Staff failed to recognise potential safeguarding incidents and had not reported these to their manager or to external safeguarding. We shared this with partner agencies, this triggered well-being checks for people. In total 15 potential safeguarding's had been identified by CQC and partner agencies to be investigated. For example, people were found with either bruises, wounds, pressure ulcers and other skin conditions and equipment that was not safe for use, which were not identified by staff.
- Staff said if they had any safeguarding concerns they would address this with the manager, however when asking about what signs they would look, staff had to be prompted by the inspector. One staff member said, "I would look at their facial reactions or hand movements if they cannot communicate verbally." However, we observed this staff member not identifying that a person was in pain and the inspector had to intervene.
- Risk assessments and support practices in some instances included unjustified restrictions. For example, bed sensors were fitted to people's beds, which meant that every time they went to leave their bed staff were alerted. There were no risk assessments or care plans which detailed the reasoning for this and if this was in the persons best interest.
- The registered manager had not ensured in all cases that people who were being deprived of their liberty had legal authority to do so.

People were not safeguarded from the risk of abuse. Staff did not demonstrate skills to be able to identify where people were at risk of harm and systems were either not in place or robust enough to highlight this. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises and that social distancing was taken into consideration. The environment did not account for people having to socially distance themselves. All armchairs were placed next to each other. In addition, occupational therapy identified equipment used for people was not always in good condition. For example,

cushions were ripped exposing the sponge, two of the bathrooms we checked were not clean and hygienic and people did not have individual slings for when they were hoisted by staff. This put people at risk of cross contamination.

● We were not assured that the registered manager and staff was making sure infection outbreaks were being prevented or managed and that personal protective equipment (PPE) was effectively used. Staff were not following government guidance about the use of PPE; this placed people at risk of infection. People were not being supported to isolate safely when they returned from hospital.

● The provider had infection prevention and control policy, which was up to date, however we were not assured that staff were following procedures set out in the policy. The registered manager had a whole home risk assessment for COVID-19, however, did not have individual risk assessment for people to mitigate the risk of COVID-19.

● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives felt that visits were not managed well but felt these were extreme and restrictive. One relative said, "I can't understand why there's no weekend visits. It's a big deal to persuade them to let me visit for a weekend and then I only get 20 minutes, and that's after the 30 minutes wait." Another relative said, "I am only allowed one visit per week for 10 minutes, not very long, really. I understand restrictions have to be implemented but a bit more flexibility would be good."

● We were not assured that the provider was preventing visitors from catching and spreading infections. For example, partner agencies noted that someone was sleeping on a mattress soaked in urine and asked staff to clean and air out the mattress. On our second day of inspection we went to check this had been actioned however we found bin liners, incontinence sheets and bedsheets placed on top of the wet mattress.

Infection prevention control systems were not robust enough to mitigate the risk of people being safe from infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People's risk assessments did not always set out all risks relating to their health conditions and manual handling support needs. Plans were not clear or coordinated. Staff were unable to talk about people's support needs and did not have the skills to identify when people were at risk. For example, a person had a high risk of developing pressure ulcers and had pressure ulcers in the past, we found staff were not supporting the person to reposition in line with the care plan and the care plan lacked information for staff.

● We observed some staff not using safe manual handling practices. We saw the deputy manager having to intervene whilst staff were supporting someone transferring. In addition, a professional fed back they had to stop staff supporting someone with a transfer as the person was in pain.

● The registered manager had not assessed or properly managed equipment. For example, a bedside table was damaged and splintered; where a bed sensor had been placed on a plank of wood, nails were exposed. Equipment such as a perching stool were damaged or not fit for purpose.

● People gave mixed views about living at the home. One person said, "It is alright here. They are ok. I get on with most of the staff." Another person said, "I do not feel safe here."

● Relatives gave mixed views of how they felt their family member was being supported in the Home. A relative said, "I am pleased [family member] is in a safe environment." Another relative said, "I raised a concern about swollen ankles. The Home did not call the GP. I rang the GP who visited and arranged for a nurse to go. I am not sure what would have happened if I didn't do it. Subsequently, my relative was rushed into hospital because of a clot in leg." The registered manager provided information which highlighted the home were taking steps to support the person with speaking with the GP.

Using medicines safely

● Staff did not follow correct processes when documenting controlled medicines. Controlled medicines were not double signed and there were two controlled drugs that were not correctly accounted for.
● People had their regular medicines when needed, however, we observed people saying they were in pain and staff did not offer any immediate pain relief. We fed this back to the registered manager the day of the inspection and they ensured the relevant health professionals visited to review peoples pain management.

Staffing and recruitment
● Staff training did not prepare staff for their roles and did not give them the necessary skills and knowledge to support people safely. Staff completed 14 subjects in a one-day induction, which was followed by multiple web-based learning courses completed, in one day. The registered manager did not check people's competency, skill, knowledge or understanding following this.
● Staff did not have training in specific courses that was key for their role. For example, staff did not have pressure care training, so were unable to identify where people were at risk of developing pressure ulcers and other skin conditions.
● The registered manager had completed a dependency tool to indicate peoples support needs. However, there were examples where people had to wait for staff to support them. One person said, "You wait ages for the toilet and then you have to wet your knickers." Another person said, "I am waiting for my breakfast, I have not had it. Staff will come around with the biscuits in a minute, but I haven't yet had my breakfast or a cup of tea. I have only had my orange."
● Staff went through a recruitment selection process. There was evidence of full employment history and checks. There were examples where staff had started before all employment checks had come back, however, the registered manager ensured relevant risk assessments were in place to mitigate risk.

Learning lessons when things go wrong
● Where safeguarding's and risks emerged, the registered manager did not gather the information to look at the trends and themes. This meant the registered manager and staff team were not able to learn from these concerns which meant that people continued to be at risk within the home.
● From the first inspection visit, safeguarding's had been raised which were shared with the registered manager. On the second inspection visit it was evident that not all identified concerns had not been shared with the staff team.

People were at significant risk of harm. Systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People were not always shown dignity or respect. For example, we observed staff leaving someone in wet clothes where they had an accident.

● People were not always shown kindness and compassion and were at risk of social isolation. We observed there being a lack of meaningful activities and very little conversations between people and staff. We found people were left in their rooms with no entertainment to occupy their time and there was limited contact with staff. For example, people did not have TV's or radios. Following the inspection, some actions had been taken, however due to the configuration of one person's room they were still not able to see the TV.

●Professionals described their experience of being in the home and what they had observed. One professional said, "There is minimal interaction generally, there are a few carers who are interacting, but this isn't across all staff. No activities observed while we have been present in the home." Another professional said, "I noted that support tends to be task orientated and routine of the service was paramount. One person was noted to be anxious as they wanted to call their family on the phone, this person had been asked to wait as staff were busy and that staff would assist later, this person became more anxious."

● Following the inspection, the home was visited by a professional who offered positive feedback from their visit. 'In the lounge all staff were busy engaged directly with residents and actively providing drinks. I told [Staff] as I was leaving that I thought staff have a lovely way with residents and everyone is smiling.'

● The registered manager was not always knowledgeable about events that occurred in the home. For example, on the second day of inspection we asked the registered manager how many people were isolating, in which they gave us the wrong information.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The management roles, responsibilities and accountability arrangements were not clear. For example, where audits and actions were completed by the Provider and registered manager, the information detailed was not an accurate description of what was found at the time of the inspection. Audits identified that care plans were up to date, and staff had specific training related to pressure care, however this was not the case.

●The registered manager told us they did not analyse accident, incidents and wound management. This impacted on how people were receiving care. For example, the registered manager had not investigated the reasoning behind unexplained bruises and if this linked to the lack of staff training relating to manual handling

●The registered manager had not addressed initial finding from our first visit with the staff team and did complete some of the immediate actions identified by CQC and partner providers..
● The registered manager did not ensure staff had received adequate training to complete their role and competency assessments were not completed.
● The registered manager did not have knowledge of key practices that should be implemented in the home. For example, some care plans had not been updated since 2019 and there were significant gaps in assessment and care planning.

Working in partnership with others
●The service did not always work collaboratively with professionals and referrals were not being made in a timely manner.
● Professionals spoke about the support they were offering the home to drive improvements; however, some felt the registered manager was not always knowledgeable about the people in the home. One professional said, "[Registered Manager] appears overwhelmed and isn't showing an understanding of the severity of the situation the home is in. Deputy manager is engaged with visiting professionals but could be better supported by others in the management team."

Governance systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the nominated individual throughout the inspection, as to how they would mitigate the risk. At the point where CQC asked for immediate action relating to the urgent risks the nominated individual sourced a consultant to support the registered manager to make improvements in the home. The provider was also working with partner agencies in the aim to ensure peoples support was safe.

● Staff said they felt supported by the management. One staff member said, "Yes I get support from my manager, I am brand new and [registered manager] has given good support."

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;
● Leading up to the inspection the registered manager had not notified us of two safeguarding incidents which resulted in people being hospitalised.

There was not an open and honest culture, the registered manager did not notify CQC of incidents that occurred in the home. This was a breach of regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulation 2009.

● People did not always receive appropriate care and treatment at the right time. Referrals for care and treatment for people in relation to wound care, pressure sores, and in some cases occupational health and speech and language had not been referred to by the registered manager. This had been identified in the first visit and subsequent visits from partner agencies.
●There were mixed views from relatives about the approach of the registered manager. Some relatives felt the manager seemed to lead well, where others felt the registered manager did not communicate effectively. One relative said. "It's woeful. You get no email correspondence and have to ring. Communications are really poor. I get the bill every month but no update." Another relative said, "It seems well managed when I phone up".

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 18 Registration Regulations 2009 Notifications of other incidents There was not an open and honest culture, the registered manager did not notify CQC of incidents that occurred in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection prevention control systems were not robust enough to mitigate the risk of people being safe from infections. People were at significant risk of harm. Systems were either not in place or robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

See decision tree

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse. Staff did not demonstrate skills to be able to identify where people were at risk of harm and systems were either not in place or robust enough to highlight this.

The enforcement action we took:

See decision tree

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were either not in place or robust enough to demonstrate the service was effectively managed

The enforcement action we took:

See decision tree