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Seabank House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 01 and 08 April 2016 and was unannounced.

Seabank House is a residential care home for people who may have learning disabilities and autism. The home is in a three storey detached building. The home provides personal care and accommodation for up to nine people, with bedrooms on the ground and first floors. The first and second floors were accessible by stairs, the second floor was unoccupied. At the time of our inspection seven people lived at the home.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the owner of the registered provider. She told us she had been working as the manager of the home for 19 years.

From our observations and the care plans we looked at we saw that the registered manager had a person centred ethos and good relationships with people who lived at the home. We found that the registered manager's approach to care was to ensure a homely environment for people and they had achieved this. The home had a laid back atmosphere; it was clear that people were comfortable living at Seabank House and treated it as their home.

People we spoke with either told us or indicated that they liked living at Seabank House. People were supported to be as independent as possible and to explore their interests and hobbies. We saw that people's care plans were individualised and at times aspirational. They guided staff to listen to the person being supported and provided appropriate guidance to staff to ensure people were involved in and made decisions about their care.

However, we found breaches relating to; regulation 12 safe care and treatment and regulation 17 good governance. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There had been concerns raised with the registered manager of Seabank House by the local authority environmental health and community infection control teams. These were concerns with regard to the maintenance of the home, the standard of cleanliness and the availability of appropriate equipment for cleaning and personal hygiene. At our inspection we found that improvements had been made in the standard of cleanliness at the home and the availability of personal hygiene equipment. There was evidence

that further improvements were underway, such as painting and plastering and the home had taken recent deliveries of further hygiene equipment.

We identified a number of concerns with regard to the safety of the homes environment, some areas of the home required maintenance to make sure those areas were safe. Also the registered manager was unsure if recommendations they had received on recent health and safety checks had been looked at and the gas safety check did not cover all gas appliances. This meant the registered manager could not be sure the home's environment was safe.

New staff members had not always been recruited safely. Background checks in respect of previous employer references had not been robust. There were also no systems in place to assess the training needs of staff or for documenting the training completed. We also found that there was no effective system in place to ensure that staff received appropriate support in the form of supervision and appraisal so that they were able to carry out their duties effectively.

Medication was administered safely. When medication was received by the home, we observed it was checked in safely. Medication administration records (MAR) were complete. However medication checks at the home were not effective. They did not record the stocks of medication, assess if the stocks of medication were sufficient or check if medication administration records (MAR) had been completed correctly. The checks had no way of showing what correct medication stocks should be. This meant that there were no adequate systems in place to check that medication had been given to people correctly.

One person required support with nutrition and hydration. Whilst it was evident that the person had received sufficient food during the eight day period of time that we looked at. There was no evidence that staff had oversight with regard to monitoring the person's food and fluid intake to ensure it was within the guidelines set by health professionals.

Seabank House had quality audits which had been completed regularly by a senior member of staff. The registered manager had not signed off the most recent six audits. These audits had not identified the issues with infection control, cleanliness, health and safety, record keeping and medication concerns that this inspection and other outside organisations had picked up on. This meant that the system in place to assess and manage these risks was not effective. There was also no evidence of the registered manager using any information gained from these audits or any other checks to come to an informed view of the quality and safety of the service provided.

The support people received at the home promoted them making choices about their lives. The registered manager had arranged for people to be supported by independent advocates when they needed to make specific decisions in their lives. The registered manager had also recently put plans in place to assess the capacity of some people to consent to their care and had completed one capacity assessment. This needed expanding and further development to meet their responsibilities under the Mental Health Act (2005).

It was clear from our observations that people were relaxed living at the home and treated it as their own home. People didn't ask permission or seek the approval of staff before doing things. People did as they chose and came and went around the home as they pleased, either deciding to have the privacy of their room or relax in the lounge downstairs. We observed that people were involved in day to day decision making at the home. We noticed this in regard to the food shopping, what was to be bought and who was going to go with the staff to the shops. The interactions we observed between staff and the people supported were respectful and positive which contributed to the friendly atmosphere.

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 safe.

People told us they felt safe living at Seabank House.

Actions were being taken to improve the home's environment. Further improvements were required to ensure the environment was safe.

Checks on the suitability of new staff were not robust. This meant that the registered manager could not be certain that staff employed were of good character.

Medication was administered safely. However monitoring of medication stocks required improvement to ensure stocks were correct and that people did not run out of medication.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was evidence that staff had received some training. There was no system in place to ensure staff received necessary training.

Information about staff supervision was inconsistent. There was no system in place to ensure staff received appropriate support and guidance.

Some nutrition and hydration needs had not been clearly documented, meaning this could not be managed effectively.

People were supported to make decisions and choices in their lives. The service was putting into place the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People told us they felt well cared for.

The registered manager and staff at the home had a caring and respectful approach to people. It was clear people had good relationships with staff and the registered manager.

People were comfortable and relaxed at the home.

The registered manager had arranged for independent advocacy to support people to make decisions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported with their social lives, to explore personal interests and to achieve personal goals and dreams.

People's care files were personalised. Sometimes the care plans did not provide sufficient detail on how people's needs would be met or what elements of a person's care required documenting.

Complaints had been documented and appropriately responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had no effective way of assessing, monitoring or improving the quality and safety of the service. This meant the service lacked clear leadership and management and also meant people were placed at risk of harm.

The registered manager had a good relationship with the people who lived at the home and the staff team.

The registered manager set a relaxed and homely atmosphere.

Seabank House

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 01 April and 08 April and was unannounced. The inspection was conducted by an adult social care inspector.

Prior to our inspection we reviewed the reports provided to us by the Local Authority Environmental Health team and the NHS Infection Control team. We checked any records we held about the service prior to our inspection including previous inspection reports. We also spoke with the local authority Quality Assurance team. After our inspection we spoke with a local advocacy organisation to gain their views on the quality of the service provided to people.

During the visit we spoke with six people who lived at the home. We looked at the care files of four people.

We did a tour of the home and checked a range of records relating to health and safety checks, medication administration, audits and the management of the home. We spoke to the registered manager and six staff. We also looked at the staff files belonging to three staff members, including recruitment records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the home, they told us they did. One staff member told us the, "Residents are safe with staff".

The registered manager had started making improvements in the safety of the home's environment. There had been recent criticisms from the local authority that some parts of the environment had become dirty and unsuitable. On our inspection we saw there had been improvements in the cleanliness of the home. On both days of our inspection maintenance people were on site painting and on the second day plastering, the home had the smell of fresh paint. In recent weeks some people's rooms had been repainted and an additional bedroom had been redecorated in anticipation of providing respite care. There was still more work to be done to bring the home to a good standard of décor and maintenance, the exterior of the building looked like it needed maintenance and repainting.

The registered manager told us she had recently introduced cleaning schedules to ensure an appropriate standard of cleanliness was maintained at the home. There had been equipment delivered to the home that the registered manager had ordered, such as soap and hand towel dispensers which were due to be installed. On the first day of our visit in the downstairs toilet we noted that there were no hand towels or other means of drying your hands. On the second day this had been rectified.

We noticed the bannister near the top of the main set of stairs had some movement in it and could be insecure. This could pose a risk to people if this came loose. A first floor fire door which led to a fire escape was corroding and had part of the window beading missing. This meant the glass in the door could become loose and unsafe. We also noticed in one person's bedroom that the source of heating for the room was an electric convector heater which was positioned approximately six inches below curtains.

On the top floor of the building each room was full of discarded items, which would be a hazard to anybody who accessed this floor. There were some signs of damp coming down from the roof which may be old or new and areas of the walls were bare brick, it looked like remedial work may have started at one time and stopped. Although nobody lived on the top floor it was part of the main building and was easily accessible to people who lived at the home from two different staircases. The floor was in such disorder that there was no clear path across rooms or down corridors. If people accessed this floor it could be dangerous. The registered manager told us they would have these items cleared.

This is a breach of regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the registered provider had failed to ensure that the premises used were safe for the purpose of providing social care.

Firefighting equipment was placed appropriately throughout the home, it was documented that these had been checked in December 2015. Fire doors were situated at intervals in the corridors. A fire safety report had been completed in October 2015, this had stated that fire alarm controls did not comply with current

regulations. We spoke with the registered manager who told us they did not know if any action had been taken to look into this matter.

There was a gas safety certificate dated December 2015. The list of items checked did not include the gas cooker in the kitchen; this meant that the registered manager could not be assured the gas cooker was safe as it had not been checked along with other gas appliances. The registered manager provided assurances that she would action this.

We looked at medication storage, stock control and medication administration records (MAR). Medication was stored appropriately in a locked cabinet in the registered manager's office. On the first day of our visit medication had been received from the pharmacy and this had been checked into the home by a member of staff. The staff member had spotted a mistake on one dose of one person's medication. The staff had reported this to the pharmacy and arranged for this to be corrected. This had shown vigilance by the staff member as the mistake was not initially obvious. The member of staff and the registered manager had recently received medication training. The registered manager told us that this training had led to them improving the way the staff checked and signed in medication.

The medication administration records (MAR) had been completed and were up to date. Medication stocks of blister packed medication were correct. It wasn't possible to check medication that wasn't blister packed as there were no records kept of this. The medication stock in blister packs indicated that people had received their medication. In people's care plans we saw that the GP's guidelines for people's as and when required medication (PRN) were available for staff to follow.

The registered manager had recently set up fortnightly checks of the medication cupboard, which were completed by a senior carer. The checks looked at the cleanliness and orderliness of the cupboard and that the medication stock was within the expiry dates. However these checks did not record the stocks of medication, assess if the stocks of medication were sufficient or check if medication administration records (MAR) had been completed correctly. These checks had no way of showing what correct medication stocks should be. They could not enable the registered manager to determine if the correct medication had been administered to people and that the remaining stock is correct. This is particularly important with infrequently used medication. For example in one person's care plan we saw the guidelines for an emergency medication that they may need. However when we checked this medication was not in stock. The registered manager told us the medication had been returned to the pharmacy the day before our visit as it had expired. This had not been recorded in the medication returns book. The registered manager told us the medication was due to be delivered imminently and they felt the person was not at risk because they used the medication very infrequently. On the second day of our visit we were told this medication was back in stock.

We looked at records for two staff that had been recently recruited. We saw that the registered manager had arranged for a criminal records check (DBS) on each candidate before starting in their role. However previous employer references had either been completed after employment had started or were not adequately robust. For example, one staff member had one reference on file that had been provided by a person who lived at the same address. The second reference for the staff member did not state the referee's relationship to the applicant, so it was unknown who the reference was from. Another staff member's file showed that their references were dated seven months after they had started their employment. The registered manager told us that this member of staff is a family member and she knew her well. We found there was no evidence that references were verified in any way after they had been received by the

registered manager. The registered manager did not have robust systems in place to ensure new staff had been recruited safely. We recommend that the registered manager put a more robust system in place for ensuring that staff are recruited safely.

The support needs of people who lived at the home varied greatly, some people required verbal prompts through the day and one person at times required support from two carers. On the care files we looked at we saw assessments of people's individual support needs. Four people who lived at the home attended day services most days during the week. On these midweek mornings there was an hour when two staff members were present to help one person with higher support needs get ready for the day. For the rest of the morning and early afternoon there was one staff member present supporting the remaining three people. We were told by the registered manager that during this time if an unforeseen event arose there was a staff member who was local and was readily available to offer support. At 2pm two staff came on duty until the night-time, also a third member of staff came on duty from 3pm till 7pm to specifically support one person at the home who needed one to one assistance. At the weekend three staff were on duty during the daytime as everybody was at home during the weekend. The staffing rota showed that the service had one waking night staff member present each night. The planned level of staffing was adequate.

Staff understood the principles of safeguarding vulnerable adults and knew the appropriate actions to take if they suspected a person was being abused in some way. They knew what outside organisations they could contact if they needed to. Staff knew some of the different forms abuse could take and were able to tell us some clues that may indicate somebody is being abused. We asked one staff member to locate the home's safeguarding policy, which they were able to do. Staff we spoke with also told us they had received safeguarding training in the previous 12 months.

People's personal monies were kept safe, expenditure and bank withdrawals were recorded and receipts kept. The registered manager audited people's monies to make sure everything was correct. This meant there were systems in place to protect people from the risk of financial abuse.

People's care files we looked at contained risk assessments which were individualised to them. There were also 'management plans' offering guidance for staff regarding some things people may do which could be dangerous, could affect others or could disrupt the home. We looked at accidents and incident records. Four minor accidents had been experienced by people who lived at the home in recent months. We saw that accident and incident records contained information about how staff had responded to the accident and incident.

Requires Improvement

Is the service effective?

Our findings

We talked with people about their experiences living in Seabank House. One person told us they liked the food, particularly the scouse they were having that day. Another person told us they liked their room, they thought it was nice.

One staff member we spoke with told us, "I like coming to work, it's quite fun, I'm always learning". Another staff member told us they had, "Done a lot of training". Staff told us they had recently received training relevant to their role. They listed manual handling, food hygiene, first aid and Deprivation of Liberty Safeguards (DoLS) as training that they had done recently. These had been delivered by outside trainers. Another staff member told us that they had recently completed manual handling training which they told us was, "Really good". One staff member told us that when they started they had an initial induction period where they shadowed a more experienced member of staff. We also noted on the staff files of new staff, it was recorded and dated when staff had finished their induction.

We saw some training certificates in the staff files we looked at. However there was no system in place to organise training for staff and to identify staff training needs. There had previously been a system in place; we saw on the registered manager's office wall there was a training matrix from 2013. We spoke with the registered manager about the lack of a system; she told us she was in the process completing a new training plan. We asked the registered manager how she organised staff training without a system to guide her, how did she know what was due and how did she ensure there were no gaps in staff training? The registered manager told us that with regard to training, "We get on whatever we can when we can".

Staff we spoke with told us they had a good working relationship with the registered manager and the she kept them up to date on matters arising. However the staff files that we looked at and some staff feedback showed that the registered manager had not supervised staff members and supported their development in an organised way. We looked at three staff files, there was one supervision documented in the three files from the previous 12 months. The registered manager did not have a system in place to ensure staff received appropriate supervision, development and guidance. This created a risk that staff members may not be equipped with up to date knowledge and the registered manager may not know the training and development needs of her staff team.

This is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the registered provider failed to implement and maintain a system to identify and organise staff training and support needs.

One person received their nutrition, hydration and medication via a feeding tube. The person's care file documented the guidelines that health professionals had given, for staff to meet the person's nutritional needs. Records of food intake were made in two different places and were contradictory. One record noted that in the previous eight days food had been received three times by the person and on one occasion had been refused. However, in the daily written records staff made passing reference to food being received by

the person seven out of the previous eight days. On one day it was recorded that the person had refused food, the other record indicated that the person had accepted it.

Health professionals had outlined the amount of water that the person needed to consume on a daily basis to stay hydrated. No record was kept of the amount of water the person was receiving. The registered manager told us how much water the staff gave the person with their medication, and before and after food. However she did not know if this on a daily basis came to the recommended amount. We worked out that on weekdays with the water intake documented by the day centre and the water taken before and after their medication, the person was receiving enough fluids. However because there were no records it was impossible to know that during weekends or when not attending the day centre if the person was receiving enough water.

There was evidence that the person had received sufficient food during the eight day period of time that we looked at. However there was no evidence that staff had oversight with regard to when the person had taken in food, how much food each time, at what speed the person took the food or when the food may expire. Food intake is an indicator of the person's wellbeing. There were also no records for the staff to ensure the person was receiving enough water. The records kept did not enable the staff to monitor the person's food and fluid intake to ensure it was within the guidelines set by health professionals.

This is a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the registered provider had failed to accurately record information relating to a person's care.

On our second visit the registered manager had set up a log book in which staff had started to record the details of the person's food intake.

The person also received a dietary supplement. It was not documented on what date the bottle of supplement was opened, so it was impossible to know how long it was being kept for and if this was within the guidelines. Also the supplement was stored with the person's medication in the medication cabinet and not refrigerated as required and outlined on the printed instructions on the bottle. On our second visit this was refrigerated but there still was no record of when the bottle had been opened.

Other people were able to help themselves to the food in the kitchen as they chose to. If anybody needed support with choosing or making their food this was offered. There was no set menu apart from a tradition of having homemade scouse on a Friday. One person told us they 'loved' the scouse. The registered manager told us they found the tradition helped people to know the midweek had ended and it was now weekend as most people's routines changed on the weekend to a more relaxed one.

Food stock was not checked or rotated frequently enough. We observed two portions of cooked food which had been packaged up and labelled by staff with a date it had to be used by. However both of these meals were beyond the use by date. When people living at the home were accessing their food without support it is important that the fridges are checked frequently as part of a daily routine to prevent people eating food beyond a safe time period.

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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During our inspection in April 2014 we noted that the registered manager was aware of their responsibilities under the MCA. The registered manager had only recently started to act upon these responsibilities. She had completed a capacity assessment for one person, this had been done in an individualised and person centred way. The registered manager agreed that there were indicators that some people's support needs may have a bearing on their capacity to make informed decisions. However the registered manager had not done a capacity assessment and subsequent DoLS application for these people. The registered manager told us the reason for this was a delay in initially understanding the process and now this was underway.

In other areas the principles of the MCA were seen in practice. We saw in care plans and in practice that people were supported to make everyday decisions as much as possible for themselves. The registered manager had facilitated for independent advocates to support people with certain decisions in their lives, enabling people to make as many decisions as possible for themselves.

There were records in people's care files that they had been supported to access health care as necessary. Advice from health care professionals was incorporated into people's care plans for staff to follow.

Good

Is the service caring?

Our findings

We asked people if they were well cared for at the home. One person replied saying, "Yes, it's nice". Another person told us that they were well cared for and it was, "Nice to be home for the weekend". A third person told us they had made friends with people who had also lived at the home for a long time.

One staff member told us they helped to care for people by, "Talking to people about their past and getting to know them better". They told us they used this information to help them provide better care. Another staff member told us, "Care is great here, people who work here actively care. It's not just a job". A third staff member told us, "I love it, the people are amazing".

It was clear from our observations that people were relaxed living at the home and treated it as their own home. People didn't ask permission or seek the approval of staff before doing things. People did as they chose and came and went around the home as they pleased, either deciding to have the privacy of their room or relax in the lounge downstairs. We observed that people were involved in day to day decision making at the home. We noticed this in regard to the food shopping, what was to be bought and who was going to go with the staff to the shops. The interactions we observed between staff and the people supported were respectful and positive which contributed to the friendly atmosphere.

We observed one person returned to the home and went to each staff member for a hug. The registered manager explained to us that this person has a low arousal routine to help them settle when returning home. The staff told us they loved coming home and had enjoyed living at the home since moving in. Although the person didn't speak with us it was clear they were comfortable and happy in the homes environment.

The registered manager told us they had arranged for independent advocates to help some people make certain decisions in their lives. During our inspection we noticed one person's advocate visiting them at the home. During this visit the person was supported to have privacy. We spoke with one person's advocate after our inspection. They told us the person they had been working with had told them they like living at the home. The registered manager had facilitated advocates getting involved to help some of the people at the home make a specific choice about their lives and explore the options they had independently. An advocate we spoke with thought this showed that the registered manager cared about people and respected their right to be independent and have unhindered choice.

Some people's bedrooms had been recently painted, people had been supported to put up photos and personal pictures in their rooms. One person who wanted to show us their room told us they liked their room very much. They had lots of personal items and keepsakes. They had been supported to use technology and had a tablet computer that they read novels on and sound equipment in their room to play their favourite music in their own space. The person also showed me and told me about their hobbies that they had been supported to explore. This showed us that people were supported in a person centred way with regard to their preferences and individual interests.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "I've had a very good day today!" They told us they had enjoyed playing dominos and bingo. Another person we spoke with told us that one evening a week they go to a local community social club, which they really enjoyed and another person who loved to read novels showed us their kindle which they had purchased with support. We communicated with one person who didn't use speech to communicate. We saw that they had pictures on their walls of shows and events they had attended. The person smiled when we asked them if they enjoyed going to the shows.

It was clear from talking to people and looking at their pictures that they were supported to socialise and to explore their hobbies and interests. People were also supported in day to day tasks. On one of the days we visited some people were going to their bank, and going food shopping.

We observed and noted from conversations that each person was treated as an individual. We noted that people's care plans were individualised and documented people likes, dislikes and preferences. Care plans outlined what people were able to do for themselves and what they may need support with and how that support should be offered. People's independence was promoted in all aspects of the care they received. We saw one document entitled 'how to support [name] with choices', which showed staff different way to respond and support people to make choices and make these choices known.

The care plans we looked at were respectful of the person and promoted people being listened to. One person's plan described how the person communicated their wishes to staff using body language. The care plan gave staff the information and encouraged them to listen and act promptly on the person's nonverbal instructions. There was also a document where over time the registered manager and staff had recorded clues which may indicate the person was not happy and a checklist for staff to help them work out what it could be the person's isn't happy about. This enabled staff to be effective listeners. This meant that there were strategies in place to ensure that the person was able to communicate with staff in a way that was meaningful to them.

Aspects of care planning could be aspirational. We saw evidence that people had been supported to achieve their dreams and wishes. People were supported with goals they had set themselves.

In addition to people's care plans the staff documented things relating to a person in a daily record book called the 'day and night book'. We noted in one book details were recorded that would enable staff and health professionals to be kept up to date with information that could help determine a person's well-being.

There was evidence that care plans had been recently reviewed and some amendments made.
We noted that occasional guidelines in care plans were not specific enough. For example it was documented in one care plan that a person's hoist should be serviced every six to twelve months. This is too vague to provide the correct information to staff.

Also care plans often did not give guidance for staff on how people's ongoing care should be documented. One example is there was instructions on how to measure a person's BMI, but no guidance on where or how to record this. Another person required support with nutrition and hydration, there was no guidance on how to record this. We recommended that people's care plans offered more specific guidance for staff when the guidance is of an important nature.

We looked at the record of complaints from the previous 12 months. Six had been recorded, the information showed that people had been listened to and resolutions or outcomes had been noted by the registered manager.

Inadequate

Is the service well-led?

Our findings

From our observations it was clear that people who lived at the home were comfortable around and had good relationships with the registered manager. One person we spoke with told us the manager was 'Nice".

One staff member told us they had previously volunteered at the home, had enjoyed the experience and had returned to take up a permanent role. Another staff member told us they thought the registered manager's approach to people was "Fantastic" adding, "I didn't think a home for people with learning disabilities could be like this, it's not institutional and it's homely".

We were concerned about the registered manager's ability to fulfil their managerial role as the staffing rota showed us that the registered manager was also a scheduled carer on the rota and worked seven days a week as a carer without a break. Between Monday and Friday the registered manager typically provided care for a day shift up to six hours, most of this time as the only member of staff present. From Friday to Sunday nights they provided care on waking night shifts as the only member of staff present. This meant that on Fridays and Mondays there was not sufficient time to rest and recuperate in-between day and night shifts. The registered manager appeared visibly tired during our visit, which highlighted that this practice could potentially be unsafe. We asked the registered manager how they ensure they had sufficient management time to lead the service effectively if they were also employed in a carer role. The registered manager was unable to tell us and did not give a reason for why working in both roles to this extent was necessary. Areas of concern regarding leadership highlighted during this inspection demonstrated that this approach to managing the home was not working

For example, we had concerns during our inspection that the registered manager did not have the time or capacity to implement and manage the systems of the home. There was evidence that medication audits had not been effective. The registered manager had failed to sufficiently address the standards of cleanliness at the home and identify any potential health and safety risks. She did not have systems in place to record and monitor the training staff had received. There were also no systems in place to ensure staff received appropriate support and supervision in their job role. There was evidence that some systems at the home had been in place previously in relation to staff recruitment, training and support but that they had not adhered to for some time.

Seabank House had quality audits which had been completed regularly by a senior member of staff. The registered manager told us that they reviewed these audits and signed them off after they had reviewed them. In the file the most recent six audits had not been signed off by the registered manager. These audits had not identified any issues with infection control, cleanliness, environmental and medication concerns that other outside organisation such as infection control and environmental health teams had picked up on. This meant that the system in place to assess and manage these risks was not effective. There was also no evidence of the registered manager using the information gained from these audits or any other checks to come to an informed view of the quality and safety of the service provided.

The quality or medication audits had not picked up on the insufficient records being made of one person's food and fluid intake. Documents in the person's care file outlined what was needed by the person; however records kept at the home were insufficient to demonstrate that this was happening. There was no monitoring by the registered manager or system put in place by her to ensure that they were meeting the person's needs. The person's nutrition and hydration relied on an ad hoc system that placed him at risk of dehydration or of consuming food or supplements that had expired (been open beyond the recommended timeframe) or had been stored incorrectly. This placed the person at potential risk of harm.

The quality audit had not picked up on health and safety issues. For example in the fire alarm report that we looked at dated October 2015 it stated that, 'Alarm controls do not comply with current regulations'. The registered manager had a lack of knowledge about the details in this report and was unsure if any action had been taken with regard to this. On the second day of our visit we were told a relevant professional had been booked to look at this. The quality audit had also failed to pick up the loose bannister on the stairs, the cluttered environment on the top floor of the home or that some maintenance issues had not been addressed. This demonstrated that the quality audits were ineffective at assessing health and safety risks. There is no evidence that the registered manager by a systematic approach or otherwise had assessed and monitored the quality and safety of the service provided.

This is a breach of regulation 17(1), 17(2)(a) and 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the registered provider failed to have effective quality assurance systems in place to monitor the quality of care and services provided to people.
We observed a handover meeting between the registered manager who had been providing care on the early shift and two staff members arriving at work. The registered manager updated staff on people one by one and spoke about their wellbeing and highlighted anything the staff may need to look out for. The registered manager also went through the tasks for the day documented in the communication book that needed to be completed and made sure the staff understood these.

We asked the registered manager to tell us what their team did well. They told us they were proud that "All my residents are happy, listened to and live full lives". They told us how people who lived at the home had strong community links and were involved in everyday things such as going to their local pub for a lunch or drinks, using the local shops and other facilities and going on holiday each year.

The registered manager described the people at the home and staff as "Family". They told us that they had managed the service for 19 years and many of the people who lived at the home had done so for many years. The most recent person to move into the home was two years ago, so people knew each other well. Also many of the staff had been working there for a long time, two senior staff members for 10 and 15 years. They described to us how staff retention and continuity of staff was important and described the team by saying, "We are a tight knit unit". They told us that the service was set up 19 years ago to have a more homely and less clinical approach to supporting people with learning disabilities. We found that this had been achieved and a homely atmosphere was provided and people told us they were happy.

The registered manager told us they were currently working on people's care plans, the home environment and completing capacity assessments for people who required this. We saw that the registered manager had organised improvements to the environment and equipment used at the home since the visits in March by the Infection Prevention and Control team and in February by the local authority Environmental Health.

Some of the policies the registered manager had in place were not adequate. The registered manager told us and we saw evidence that they were in the process of updating the home's policies. Some of the policies that were currently in place did not provide essential information or guidance for staff. For example the

whistleblowing policy did not mention or give details of the outside organisations a whistle blower could contact. The safeguarding policy didn't give guidance for staff on what they should do if they suspected abuse was taking place or which organisations they could contact and receive support from. This meant there was a risk that less experienced staff may lack appropriate guidance on what to do in a given situation.

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 did not take formal enforcement action at this stage. 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 Because the registered provider had failed to ensure that the premises used were safe for the purpose of providing social care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Because the registered provider failed to have effective quality assurance systems in place to monitor the quality of care and services provided to people.

The enforcement action we took:

Issued a warning notice