

The Seymour Home Limited

Seymour Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Seymour Care Home is residential care home located in East Manchester. The home is registered with the Care Quality Commission (CQC) to provide personal care and accommodation for up to 27 people over the age of 65, including people living with dementia.

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

At this inspection we identified three breaches of regulations in relation to safe care and treated, dignity and respect, and good governance. We have also made two recommendations in relation to medicines management and responsibilities around duty of candour.

We reviewed the care records for eight people who were identified to us as having additional needs in relation to eating and drinking. We found risks associated with eating and drinking were not always managed safely. This placed people at risk of harm.

Staff were not organised, supervised and deployed effectively. There was an absence of visible leadership and management 'out on the floor'. This meant there were lost opportunities to challenge poor practice and to lead by example.

The management of people's medicines was not consistent and failed to follow national best practice guidance. A variety of issues were identified in relation to Medicines Administration Records (MAR), medicines prescribed to be given 'as and when required' and for medicines that were given to people covertly in food or drink.

We completed several formal periods of observation in communal areas and saw that staff did not always interact with people in a caring or compassionate manner. We also found care and support provided to people had become task-and-time oriented with no meaningful effort made by staff to positively engage with people other than when delivering care related tasks.

There had been a deterioration in systems and processes which previously had enabled lessons to be learned and practice changed to improve care. This is evident from the deterioration in quality and safety found at this inspection and a failure to sustain previous improvements.

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

Rating at last inspection (and update)

The overall rating for this service at the last inspection was Good (published 16 July 2021). At this inspection the overall rating has deteriorated to Requires Improvement.

Why we inspected

The inspection was prompted in part by notification of a specific incident. Following which a resident of the care home died. This incident is subject to an ongoing investigation. As a result, this inspection did not examine the specific circumstances of the incident.

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

Enforcement

We have identified three breaches of regulations in relation to safe care and treated, dignity and respect, and good governance. Please see the action we have told the provider to take at the end of this report.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the 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.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement ●

Seymour Care Home

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 was carried out by two inspectors.

Service and service type

Seymour Care Home 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

The inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. 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 also reviewed the providers 'report of actions' that had been sent to us following previous inspections. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with four people who lived at Seymour Care Home about their experience of the care provided. We also 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 also spoke with four relatives by telephone.

We spoke with six members of staff including the registered manager, deputy manager, senior carers and care assistants.

We reviewed a range of records including care plans and records associated with medicines management. A variety of records related to the quality, safety and management of the service were also reviewed.

After the inspection

The provider sent us documentary evidence in respect of improvements that had been made to care plans and policies and procedures.

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 Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Whilst we did not focus on the specific incident which triggered this inspection visit, we did complete a wider review of how risks associated with eating and drinking were managed.
- We reviewed the care records for eight people who were identified to us as having additional needs in relation to eating and drinking. We found care records were reflective of the International Dysphagia Diet Standardisation Initiative (IDDSI) standards. However, for two people, risk management and oversight of their dietary needs was not managed effectively.
- For one person, a handwritten section in their care plan dated 25/10/2021 stated '[Person] diet has been changed to pureed diet and mildly thickened fluids by SaLT (Speech and Language Therapy) team.' However, within the same section of their care plan, it then went on to state '[Person] to have small bitesize diet and stage 2 thickened fluids.' This conflicting information placed this person at an increased risk of harm by receiving the wrong type and consistency of food and fluids.
- For a second person, we found contradictory information in their care plan versus information held in kitchen in relation to thickened fluids. This person's care plan and SaLT assessment guidance stated they required Stage 1 thickened fluids (one scoop of thickener) but the document relied upon by kitchen staff stated Stage 2 thickened fluids (two scoops of thickener). We spoke with the chef about this and whilst they stated it was the responsibility of care staff to provide drinks, they confirmed to us staff routinely gave two scoops of thickener in this person's drinks. This meant the thickening agent was not being given as prescribed. Furthermore, a review completed by the registered manager in November 2021 had failed to identify the contradictory recording of information and the practice of staff.

Risks associated with eating and drinking were not always managed safely. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks and safety certification in relation to building and premises had been completed and were in order.
- People had a Personal Emergency Evacuation Plan (PEEP) which gave guidance on what support a person would need during an emergency evacuation situation.

Staffing and recruitment

- Staff were not organised, supervised and deployed effectively. Whilst there were enough staff on duty, there was an absence of visible leadership and management out on the floor. This meant there were lost opportunities to challenge poor practice and to lead by example.

We recommend the provider completes a review of leadership and management within the home to ensure staff are deployed and supervised effectively.

- Safe recruitment practices had been followed. All relevant pre-employment checks, had been completed, including obtaining references from previous employers and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Using medicines safely

- The management of people's medicines was not consistent and failed to follow national best practice guidance. For example, Medicines Administration Record's (MAR) should only be handwritten in exceptional circumstances yet we saw two examples where handwritten MAR's were being routinely produced. For one person, their handwritten MAR detailed three medicines but the handwriting was poor and illegible in places. For a second person, who had been prescribed eye drops, the handwritten record was also illegible, and it was not clear which eye drops had been prescribed.
- Where a medicine is prescribed to be given 'as and when required' this is often referred to as a 'PRN medicine' and should be accompanied by a 'PRN protocol' detailing the circumstances in which the medicine should be given. However, the current PRN protocols were not detailed enough.
- Some people require their medicines to be hidden in food or drink. These are often referred to as 'covert medicines.' Where a medicine is given covertly, there is a clear framework in place covering the legal aspects of giving it and checks to ensure it can be given in food and drink without changing its effectiveness. However, this systematic approach was not always taken. For example, for one person, their GP had given approval for covert medicines but it was not clear why this was in their best interests and there was no record of involvement from a pharmacist.

We recommend the provider consults current national best practice guidance for managing medicines in care homes.

Learning lessons when things go wrong; systems and processes to safeguard people from the risk of abuse

- There had been a deterioration in systems and processes which previously had enabled lessons to be learned and practice changed to improve care. This was evident from the deterioration in quality and safety found at this inspection and a failure to sustain previous improvements.
- Established systems and processes were in place which sought to protect people from a risk of abuse. Staff we spoke with understood their individual and collective responsibilities to safeguard people. However, the registered manager had failed to follow due process after an event in which the relevant safeguarding authority should have been notified. This issue is addressed in the Well-Led section of this report.

Preventing and controlling infection

- We were assured the provider was preventing visitors from catching and spreading infections.
- We were assured the provider was meeting shielding and social distancing rules.
- We were assured the provider was admitting people safely to the service.
- We were assured the provider was using personal protective equipment effectively and safely.
- We were assured the provider was accessing testing for people using the service and staff.
- We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; ensuring people are well treated and supported; respecting equality and diversity

- We completed several formal periods of observation in communal areas and saw that staff did not always interact with people in a caring or compassionate manner.
- We observed one person showing clear signs of distressed behaviours, yet staff appeared indifferent to this and did not provide any meaningful reassurance or comfort.
- At lunch time, we observed a member of staff supporting two people simultaneously with their meal, moving between each one when it was deemed 'their turn' to be supported with their meal. This was undignified and did not support any attempt to promote independence.
- Care and support provided to people had become task-and-time oriented with no meaningful effort made by staff to positively engage with people other than when delivering care related tasks.

People were not always cared for in a dignified and respect manner. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- During the period of COVID-19 restrictions, the registered manager had sought to ensure people and their representatives had been involved. This included sharing of information via email and telephone, and through virtual online meetings.
- Information about independent advocacy and support services was available within the home. An advocate is a person who is independent of the service and who can support people to share their views and wishes if they want support.

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 Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems for audit, quality assurance and questioning of practice had deteriorated since our last inspection. This is evident from our findings clearly outlined in the Safe section of this report.
- Furthermore, we looked at records entitled 'Stand up meetings.' We were told such meetings regularly took place and were an important method of sharing information with staff. We were also told details of meetings were recorded so that staff who were not present could access the information when required. However, from 03 August 2021 'stand up meeting' records ceased to be created. On 22 November 2021 records of such meetings started again, but then from 27 November 2021 no further records were available. We spoke with the registered manager about these missing records and established that for good reason, the registered manager had been absent from work for a period of time. However, we could not be assured whether these important key information sharing meetings had taken place in the absence of the registered manager.
- We reviewed a variety of records related to the day-to-day care and support provided by staff. One such record was described as a 'Day Book' where staff would complete a written record on every shift of events that had taken place. We looked at entries made between 21 August 2021 until 08 November 2021 and found multiple entries made by night staff that indicated they were routinely getting most people up, washed and dressed before the day shift came on duty. We saw no evidence to support it was the preference of those people to get up so early.
- We spoke with staff about this issue who confirmed to us the night staff did routinely get most people up before the day shift commenced. We were also told it was a directive from senior carers to do this. We spoke with the provider and registered manager about this issue and they denied such practices took place. We therefore asked for a sample of CCTV footage from communal areas, but due to the passage of time this was not available.
- We concluded there was insufficient evidence to demonstrate whether or not night staff were getting people up excessively early. However, given the fact night staff were consistently recording this practice had taken place, the conflicting evidence meant we were not assured of the accuracy and reliability of information being recorded.

The evidence outlined above demonstrates systems and processes for good governance were not operated effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- In our last inspection report we described how we had spoken at length with the registered manager about the importance of ensuring improvements were sustained and how they should strive for continuous service improvement. We also highlighted the role of the provider in ensuring quality improvements are embedded into future business development plans. However, as evidence throughout this report, there had been a clear deterioration in practice and a disregard for sustaining quality and safety improvements.
- In our last report we also made reference to our findings from October 2020 and our recommendation at that time that the provider should take steps to alleviate elements of a 'closed culture' within the home and to create an environment which supported staff to 'speak up' and raise concerns, safe in the knowledge they would be taken seriously. Our findings at this inspection demonstrated a regression back to previous poor practices. This, coupled with a lack of effective visible leadership, meant the culture within the home continued to be a cause for concern.

The provider had failed to act on previous recommendations and failed to sustain improvements to support continuous learning. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- In the Safe section of this report we referenced how the registered manager had failed to follow due process after an event in which the relevant safeguarding authority should have been notified. We are reviewing this matter outside of this inspection framework and in tandem with our investigation into the serious specific incident which triggered this inspection.
- More widely, given the current culture within the home and complacency around poor practice, we were not assured that systems and processes which enable openness and honesty when something goes wrong were operated effectively.

We recommend the provider reviews and acts upon their legal responsibilities around duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People continued to be encouraged to provide feedback on how the home was managed. The registered manager sought views from people, their relatives and staff about how well the service was supporting people through annual questionnaires. However, response rates remained low.

Working in partnership with others

- Opportunities for partnership working had been reduced during COVID-19 restrictions, but good working relationships continued to be in place with local primary care teams such as GP's, district nurses and therapists. The registered manager spoke with us about their plans going forward back to 'business as usual' and restoring links with others.

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	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>Dignity and respect 10 (1) Service users must be treated with dignity and respect.</p> <p>Staff did not always interact with service users in a caring or compassionate manner. This included when service users showed signs of distressed behaviours and undignified support at meal times</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users.</p> <p>Risks associated with eating and drinking were not always managed safely. This placed people at risk of harm.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>Systems for audit, quality assurance and questioning of practice had deteriorated since</p>

our last inspection. There had been a clear deterioration in practice and a disregard for sustaining quality and safety improvements.