

Seely Hirst House

# Seely Hirst House

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

We inspected Seely Hirst House on 31 July, 1 and 13 August 2018. The inspection was unannounced. Seely Hirst 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. Seely Hirst House accommodates up to 38 people in one building, which is split across three floors. On the day of our inspection 33 people were living at the home.

Seely Hirst House was rated as requires improvement at our last inspection in August 2017. During this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing, person centred care and 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 the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was no registered manager in post 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 had been absent since March 2018 and left their post in June 2018. There was an acting manager in place and they told us plans were underway to recruit to the post of registered manager. We will monitor this.

During this inspection we found concerns about the safety of people living at the home. People were not always protected from risks associated with their care and support, such as falls. Risks associated with people's behaviour had not always been effectively assessed or managed. Some areas of the home and equipment used in people's care and support was not always sufficiently clean and hygienic. There were not always enough staff to ensure people's safety. This had resulted in some staff using unsafe moving and handling techniques.

Overall, medicines were stored and managed safely and people received their medicines as required. However, topical creams were not always applied as prescribed. Systems were in place to protect people from improper treatment and abuse, at the time of our inspection several concerns were being investigated by the local authority safeguarding adults team. Safe recruitment practices were followed.

People were at risk of poor fluid intake or dehydration. Mealtimes experiences were not always positive and people were not always served the correct diet. Improvements were needed to ensure people were supported to have maximum choice and control of their lives. Staff had adequate training and supervision. People had access to healthcare and their health needs were monitored and responded to, there was detailed information about people's health needs in their care plans. There were systems to share information between services to ensure care was person centred. The environment was adapted to meet people's needs.

People did not always receive consistent, person centred support. Staff did not always respond to people's distress and discomfort and did not always treat people in a respectful and dignified manner. Despite this, people told us staff were kind and caring in their approach. People were involved in day to day decisions about their care and support. There were links with local advocacy services to enable people to express their views if needed. People's right to privacy was respected and their independence was promoted.

The home was not consistently well led. Systems to monitor and improve the quality and safety of the service were not always effective. Action was not taken to improve practice based on learning from incidents and care plans were not always updated as a result of incidents. Accurate and up to date records were not kept of people's care and support and sensitive personal information was not always stored securely. Staff did not always feel valued or involved in the running of the home. Whistleblowing on poor practice was not promoted or supported by the provider. People and their relatives were involved in giving their views on how the service was run. The management team told us they were committed to addressing the issues found at this inspection.

## 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 consistently safe.

Risks associated with people's care and support were not always managed safely.

There were not always enough staff to ensure people were provided with safe support that met their needs.

People received their medicines as required.

People were protected from improper treatment or abuse. Safe recruitment practices were followed.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

People were not always supported to drink enough. People were positive about the food, but people's mealtime experience was variable.

Some improvements were needed to ensure people were supported to have maximum choice and control of their lives.

People were supported by staff who received training and supervision.

People had access to healthcare and their health needs were monitored and responded to. The environment had been adapted to meet people's needs.

### Is the service caring?

**Requires Improvement** ●

The service was not consistently caring.

People did not always receive person centred support that was based upon their preferences. Staff did not always treat people in a respectful and dignified manner.

People told us staff were kind and caring and they felt involved in day to day decisions about their care.

People's right to privacy was respected. People were encouraged to maintain their independence.

### **Is the service responsive?**

The service was not consistently responsive.

People did not always receive care that was responsive to their needs and preferences. People could not be assured they would receive the support they required, as staff did not always use care plans to inform their care and support.

People were provided with the opportunity to get involved in activities but at times people lacked meaningful occupation.

There was a system to manage complaints; however, this was not always effective in ensuring people's complaints were handled appropriately.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well led.

Systems to ensure the quality and safety of the service were not always effective. Accurate and up to date records were not kept of people's care and support and sensitive personal information was not stored securely.

Staff did not always feel valued and sometimes felt their views were not listened to.

People were involved in giving their views on how the service was run.

The management team were committed to improvement and were responsive to concerns raised during this inspection.

**Requires Improvement** ●

# Seely Hirst 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, to explore concerns received in relation to safety and quality and to provide a rating for the service under the Care Act 2014.

We inspected the service on 31 July, 1 and 13 August 2018. The inspection was unannounced. The inspection team consisted of two inspectors and Assistant Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with seven people who lived at the home and the relatives of two people. We also spoke with three members of care staff, an activity coordinator, a member of the catering team, a member of the maintenance team, the acting deputy manager and the acting manager. On 13 August we spoke with a further eight staff on the phone.

To help us assess how people's care needs were being met we reviewed all or part of eight people's care records and other information, for example their risk assessments. We also looked at the medicines records of nine people, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. 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 did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, we gave the provider the opportunity to share this information during our inspection.

We asked the acting manager to send us a copy of various policies and procedures. We received these prior to this report being completed.

# Is the service safe?

## Our findings

People were not always adequately protected from the risk of falls. Records showed one person had recently sustained an injury resulting from a fall in a communal area. Opportunities to reduce future risk had been missed. Their mobility care plan and risk assessments had not been reviewed since the incident, consequently, they did not contain information about reducing the risk of repeat events. During our inspection we observed the person to be in the same situation which led to the previous fall. Staff were not present in the area at all times and action was not taken to ensure their safety for a period of 25 minutes. This placed the person at risk of experiencing another fall.

The risk of people falling from their bed was not always managed safely. During our inspection we saw a person on their bed, there were cushions pushed in-between the wall and the mattress. The acting manager told us this was to prevent them from slipping down the side of the bed. This was not a safe method and placed them at risk of sustaining an injury. After our inspection, the acting manager informed us that an external health professional had visited and advised this arrangement posed a risk of entrapment. The acting manager said they were now addressing the issue.

Risks associated with people's behaviour had not been effectively assessed or managed. One person sometimes behaved in a way that placed them, and others, at risk of harm. Their care plan contained guidance for staff about techniques to be used to calm and reassure them. However, we found three recent records which showed staff were not routinely following this. For example, one record described the person being physically aggressive towards staff, instead of using techniques in the care plan, staff documented they told the person 'it's not nice.' We found six recent behaviour records documenting that another person was often resistant to personal care, resulting in them behaving in a way that placed them and others at risk. There was no reference to this in any part of their care plan. Consequently, there was no guidance for staff about how to manage this behaviour safely. This had resulted in staff developing their own techniques. A behaviour record recorded that in response to resistance to personal care, a staff member held the person's hands until care was finished. There was insufficient detail about the nature of this intervention and this was not a method specified in their care plan. This lack of information placed the person at risk of unsafe support.

Topical creams were not always applied as directed. We looked at Topical Medicine Administration Records (TMAR) for five people all of which failed to evidence that creams had been applied as directed. For example, one person was prescribed a cream to treat dry skin. The TMAR documented that this was not applied on three recent occasions because there was 'none in room.' This failure to apply topical creams as directed may have had a negative impact on people's skin integrity.

Equipment used in people's care and support was not sufficiently clean, this did not promote good infection control and prevention practices. During our inspection we looked at five walking frames and all were marked, sticky and unclean. Moving and handling equipment, including hoists and the rotunda, were heavily soiled with crumbs, hair and other debris. The underside of commodes in two bedrooms were heavily soiled and had not been effectively cleaned and nor had the underside of shower seats. The



medicines room had not been cleaned to a sufficient standard. The sink was not clean and the bin and surrounding wall were marked with splashes of sticky liquid. Furthermore, equipment used in the administration of medicines was not clean. Aero chambers, used to administer inhalers, were opaque due to a build-up of medicine inside and the masks attached had not been cleaned. This was not hygienic and did not promote the control and prevention of infection.

Some people's relatives and staff commented that the environment was not always clean and hygienic. A relative told us, "Sometimes it doesn't smell very good. They don't always clean it quickly." A member of staff told us there were specific times when there were not enough staff to keep the home clean. They said, "It is often up to the carers to clean and we don't even have time to care sometimes, let alone clean. The bathrooms can become a mess, not by anyone's fault but because there is no time to clean."

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to meet people's needs and ensure their safety. Although people living at the home were generally positive about staffing levels, most staff told us there were not enough staff. One member of staff told us, "I feel there are not enough staff. They could do with more staff on shift as the residents they have at the moment require more support." Another member of staff commented, "When I started there was seven staff on shift and now we only have five, I know we have a fewer residents but now we have more people with more needs." A third member of staff said, "No there are not enough staff, there are a lot of high need residents and staff can struggle to get to them on time, or can rush when with them." The acting manager told us was no formal tool used to calculate staffing levels but said they regularly reviewed staffing levels based upon people's needs. However, staffing rotas showed occasions where the number of staff in shift fell below the levels specified by the acting manager.

Insufficient staffing levels had led to unsafe care practices. Before our inspection we received concerns that moving and handling practices which required two members of staff were sometimes being undertaken by a single member of staff. Staff told us they were aware that this did sometimes happen. One member of staff told us, "I would not. I have been asked to do a double on my own but I will not risk my health and their safety. I have been told by [senior member of staff] to do a double on my own to get people up quicker." Another member of staff said, "I heard people say they have helped someone (who needed two staff) to get washed on the commode then got someone to help the transfer to save time." A third member of staff commented, "I have heard others talk about it and I know it has happened." This was not a safe practice and placed people at risk of potential injury due to poor moving and handling practices.

Staff were not always effectively deployed to ensure people's safety. Prior to our inspection we were informed of the outcome of a safeguarding investigation into a fall which had recommended that care staff must be present in the lounge to reduce the risk to a person. This learning had not been applied to others living at Seely Hirst House to ensure their safety. A mobility care plan stated another person, 'lacked capacity and did not fully understand the importance of walking with their frame,' they were at high risk of falls and had experienced recent falls. The acting manager told us staff should always be present in communal areas to observe people at high risk of falls. Despite this, we observed several occasions where this person was unsupervised in communal areas. This placed them at risk of falls.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and processes were in place to minimise the risk of people experiencing

avoidable harm or abuse. One person said, "Yes I am safe. Everybody is very kind to me. There is absolutely no abusive behavior." A relative told us, "I have never seen staff being abusive." Staff told us, and records showed, they had regular training in safeguarding adults and they were knowledgeable about indicators of abuse and knew how to respond should they have any concerns. One member of staff said, "I have had safeguarding training, I know to report any concerns to the manager and if it is not dealt with I can go to the CQC and whistle blow. I have not had any concerns about the home." Another commented, "I feel I could recognise abuse and I would be confident to report it." Staff felt confident that any issues they reported would be acted on appropriately. The acting manager had a good understanding of their role to report any concerns to the local authority safeguarding adults team if required.

At the time of our inspection, the local authority safeguarding team was investigating several safeguarding concerns, primarily into allegations of neglect of people's personal care needs. These investigations were not concluded at the time of writing this report.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Some further work was required to ensure people were fully protected from risks associated with the environment. Nottinghamshire Fire and Rescue Service had visited the home recently and made several recommendations to ensure people were protected in the event of a fire. The acting manager told us arrangements had been made to update the fire risk assessment and undertake other works to ensure compliance. There were personal evacuation plans detailing how each person would need to be supported in the event of an emergency such as a fire. The Food Standards Agency had inspected the home in February 2018 and given it a food hygiene rating of two, which means 'some improvement is necessary.' We spoke with a member of the catering team who explained improvements they had made since the inspection. We observed the kitchen area to be clean and well maintained, food was stored safely and staff followed food hygiene procedures.

Other than the above issues with topical medicines and creams, we found people received their medicines as required. People told us they got their medicines when they needed them. One person told us, "I get medicines three times a day. Staff told me what they were for. I think they have been reviewed. I do discuss if the tablets are any good." Information was available for staff about how each person preferred to take their medicines and any allergies they had. People's medicine records also contained a photograph of the person to aid identification and prevent errors. Medicine records indicated people received their medicines as prescribed. Staff received training in medicines administration and their competency was checked regularly. Policies were in place for the safe management of medicines and overall, medicines audits were effective in identifying and addressing any areas for improvement.

## Is the service effective?

### Our findings

People were at risk of poor fluid intake or dehydration. Fluid records did not evidence that people were provided with enough to drink. We looked at fluid records for five people, all of which showed days where fluids offered were significantly below the recommended amount. One person's fluid records documented that they should consume two litres of fluid a day due to a health condition. However, fluid records documented they had only been offered the required amount on two of the eight days prior to our inspection. On four of these days they were documented as being offered below one litre and there were no records at all for two days in this period. Another person was reliant upon staff to meet their hydration needs. They were at risk of dehydration and had recently been admitted to hospital as a result. Despite this, fluid records did not evidence that they were provided with enough to drink. For example, one record documented they were only offered 200ml of fluid in a day. There were no fluid records kept for two of the eight days prior to our inspection, which meant staff would not be able to monitor how much fluid the person had consumed. This failure to effectively monitor people's fluid intake placed them at risk of dehydration.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw people received assistance to eat as needed. However, staff told us they were not always able to provide this support in a dignified manner due to staffing levels. One member of staff told us, "Sometimes I have to feed two residents at the same time to make sure everyone gets food at lunch time as there is not enough staff to support with meals and I don't want the food to go cold." Another member of staff said, "There are a lot of people to assist at lunch and not always enough staff, everyone will be assisted but some people have to wait for their lunch or we have to help two people at once. I know this is not right but we feel it is better than people waiting ages for their lunch." This was not a dignified practice and did not promote good nutritional intake.

The catering team had access to information about people's dietary needs and staff had access to guidance in care plans. However, people told us and records showed this guidance was not always followed. One person needed their food cut into bite sized pieces, but they said staff did not always do this for them and this caused them to struggle when eating. Records showed two recent instances where people had not been served the correct diet. Following this, action had been taken to improve systems in the kitchen and during our inspection we saw meals prepared and labelled for people who had specific requirements.

Overall, mealtimes were sociable experiences with people chatting with friends and staff. People had choice about what they ate. A member of the catering team attended meetings with people living at the home to check they were happy with the food choices available and revise the menu accordingly. Two main meal options were prepared each day and people made a choice as the food was served. People were offered alternatives if they did not wish to eat what was on the menu. Snacks, including fresh fruit, were available to people at intervals throughout the day. People were served adequate sized portions of home cooked food. Whilst most people were positive about the quality of the food one person told us the home did not cater for

their cultural preferences. We saw they ate very little of the food they were offered. The acting manager told us they had identified this and were in the process of sourcing food to meet their needs.

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

There was a risk people's rights under the MCA may not be upheld. Capacity assessments had not always been completed to reflect people's decision-making abilities. Some people's care plans recorded they were 'not for hospital admission.' Records showed they lacked capacity to make other similarly complex decisions. However, their capacity to consent to this had not been assessed and there was no evidence that consideration had been given as to whether this was in their best interests. Where mental capacity assessments had been completed, they were not always detailed. For example, one person had been assessed to lack capacity to make a decision about a restriction placed upon them. The assessment lacked detail on how the person's capacity had been assessed. The acting manager told us they would make improvements to ensure people's rights were respected.

Despite this, people who could speak with us told us staff involved them in decisions about their care. One person told us, "I get asked (by staff) what I want and don't want." Care staff understood the MCA, they knew how it impacted on their day to day work and told us they were committed to enabling people to have choice and control. One member of staff told us, "I have had training on the MCA I know it is about choice, us housekeepers are not involved in the care but we ask before going into someone's room if they are still in there."

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The management had made applications for DoLS where appropriate.

People were supported by staff who had the skills and knowledge to provide good quality care and support. This was reflected in feedback from people living at the home and their relatives. One person told us, "They (staff) know how to do the work." Another person said, "Yes they know their job." Staff were generally positive about the training they had. Records showed staff had received the relevant training to equip them with the knowledge and skills they needed, such as, medicines management, equality and diversity and fire safety. Some staff also had training specific to people's individual needs, such as continence and diabetes care.

New staff were provided with an induction period when starting work at Seely Hirst House. Induction included training and shadowing more experienced staff. New staff were given time to reflect and learn from their experiences. Staff completed the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe and compassionate care and support. Staff told us they felt supported and records showed most staff had regular supervision of their work. One member of staff told us, "Yes (I have supervision), every 3 months; this is our opportunity to say if anything is wrong." Staff also had an annual appraisal of their performance.

People's day to day health needs were met. People told us they had access to health care services and that

professionals visited the home regularly. One person told us, "I can see the doctor when I want. I've seen the optician here. I think they asked me about all my health needs at the beginning when I came here." Records showed people were referred to healthcare services when their needs changed. There was evidence of communication with dementia outreach services, nurses, GPs, chiropody and opticians as needed. When people had specific health conditions care plans contained detailed information and guidance for staff.

Seely Hirst House was part of an NHS vanguard (an initiative to improve services for older people in care homes). This meant staff had access to 'Telemedicine;' 24-hour nursing support over the phone or internet. Staff used this service regularly to access specialist advice and prevent unnecessary hospital admissions.

Systems were in place to share information across services when people moved between them. Assessments were conducted prior to people moving into the home to inform their care plans. This helped ensure people's care and support was person centred when they moved between services. The electronic care planning system was used to generate a hospital pack which provided a summary of people's needs if they went into hospital. The service was also part of the 'red bag' scheme. This scheme is designed to share information and important items, such as medicines, between care homes and hospitals, to ensure care is person centred.

Seely Hirst House is situated in large residential premises. Adaptations had been made to the environment to accommodate people's physical needs. There was a stair lift and lift to enable people to move freely between the two floors. People had access to call bells in their bedrooms, this allowed them to call for staff support if needed. People had individual bedrooms and most were personalised to reflect their preferences. There was a well-maintained, accessible garden. People's needs associated with dementia or memory loss had also been identified and catered for in the decoration of the home. Dementia friendly signage was used around the building to help people navigate around the home.

## Is the service caring?

### Our findings

People did not always receive consistent, person centred support. We saw six different staff members attempt to assist a person to eat in the space of 25 minutes, making short attempts to encourage them to eat and then moving on to a different task. The person did not eat any food. This support may have been confusing for the person who had advanced dementia.

Staff did not always respond to people's distress and discomfort. We saw one person indicating they wished to be supported with personal care for a period of one hour twenty minutes. Three staff members interacted with them in this period, but none of them acted to tend to their personal care needs. Another person was calling out and making vocalisations that indicated distress. A staff member noticed this and told them they would come back and see them. This staff member did not return to see the person for the hour in which we conducted observations. Another staff member in the room was completing records and did not acknowledge or respond to the person's vocalisations. This demonstrated staff were not always responsive to people's needs.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always communicate with people in a respectful and dignified manner. While we observed some very positive interactions between staff and people living at the home, this was not consistent. We heard staff talking about people without involving them in the conversation. For instance, we observed a member of staff say to another member of staff, "What does she want," the other staff member said, "She's had pudding, she might have some more in a bit." This conversation was held right next to the person but staff did not attempt to involve the person. This failure to acknowledge and communicate with people was undignified and disrespectful.

The language used by staff was not always dignified. During our inspection we observed a staff member assisting a staff member hoisting a person, the language used was that which would be used with a young child, for example they said, "Good girl," on several occasions. On other occasions staff referred to people as tasks, for instance a member of staff shouted across the busy lounge area, "I've only got three left to do," referring to assisting three people to bed. This use of language was not dignified or respectful.

The quality of interactions between staff and people living at the home was variable. This was reflected in the comment of one person who told us, "I think a bit of love and affection is missing." When we arrived at the home the lift was out of service, consequently an ad hoc living room had been implemented upstairs. Six people were present in this room with one member of staff. The member of staff was completing records and did not initiate conversation with people or provide any stimulation. Consequently, four people gradually fell asleep. Later, we observed 20 people in a communal living area, one staff member was present in the room, but was completing records. They did not initiate communication, everyone sat in silence, either watching the TV or passively watching others.

Despite the above, overall, feedback from people living at the home was positive. One person told us, "Staff are very nice, kind and gentle. They never shout." Another person said, "I like staff's honesty with me. I like who they are and what they do for me." A relative commented, "The staff are caring and take their time with people. They are not dismissive of people." Another relative told us, "They have a lot of patience with [relative]. They have good and bad days."

People told us staff knew them well. One person told us, "The staff know me and respect me. I can't find fault with them." Another person said, "The staff know me. I can be funny sometimes and they still treat me well." A relative told us, "The staff here know what [relation] likes and dislikes and ask them." People also told us staff listened to them. One person said, "The staff are very approachable. They all listen." Another person told us they trusted staff and commented, "I was worried about something and talked about it with a carer, who I trust. She helped me."

People told us they felt involved in decisions about their care and support. One person told us, "Staff always explain what they're going to do to do for you. They ask me when getting me dressed which clothes I want. I'm glad I've got a place like this." Although few people could recall being involved in the development or review of their care plans, people's relatives told us they had been involved. One relative commented, "Yes I know about [relation's] care plan. We review the plan every three to six months." People's involvement was also evident in care plans which contained detailed information about their background and what mattered most to them.

People had access to an advocate if they wished to use one. There was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

People were supported to keep in touch with family and friends and visitors were welcomed in to the home. One person told us "My children and grandchildren visit me here. They can come when they want to." A relative said, "The staff know me and I am very welcome here." The acting manager told us that there were visiting restrictions in place for a relative of someone living at the home but added this had been agreed with the person and family. There were no other restrictions on visitors. Friendships had developed between some people living at the home and we saw people spent time together enjoying each other's company.

Staff respected people's right to privacy. One person told us, "Staff tap on the door and check things are alright with me. I feel respected and have privacy." Another person told us, "Staff knock on the door when coming in so that I get privacy. The curtains are drawn when I get dressed." Staff understood the importance of respecting people's privacy and did so throughout our inspection visit.

People were supported and encouraged to maintain their independence. This was reflected in people's feedback and comments from people's relatives. One person told us, "I am very independent but getting worse. They arrange different things you can do. The girls will take me for a walk." Another person told us, "I'm new so staff and I are working out the right balance." A relative told us, "The staff don't get in [relation's] face and don't take over." During our inspection we saw staff promoted people's independence by encouraging them to walk rather than using a wheelchair. Care plans contained clear information for staff regarding areas where people were independent and where they needed support.



## Is the service responsive?

### Our findings

People did not always receive care and treatment that met their needs. Before our inspection we received concerns that people's personal care needs were not always met resulting in them being left for prolonged periods in soiled clothing. The acting manager told us, that in response to these concerns, they had implemented a new process to ensure people were regularly assisted with their continence needs. However, this did not evidence that people had been offered regular assistance with continence. Records showed gaps of up to eight hours between people being assisted with their continence. Records for other people were blank. This finding was supported by feedback from staff who told us staffing levels sometimes meant they could not support people with their continence as quickly as they would wish. One member of staff told us, "I feel sometimes residents can get left as there are a lot more people who need two staff. We have had to get the next shift to help toilet people after lunch as we have not got to everyone." Another member of staff told us, "They are assisted as much as possible but it depends on how many staff, some people can be left." A third member of staff said, "I have seen residents that have been sitting there wet or come out of their room undressed." This demonstrated people did not receive regular support to attend to their continence needs.

Before our inspection we received concerns that people did not have regular baths or showers. During our inspection we found limited evidence to demonstrate people had been assisted to have regular baths, showers or washes. Records of personal care for one person, who was reliant upon staff to attend to their personal care needs, documented that they had only been assisted to wash once in July 2018. Another person's records did not contain any evidence of bathing or washing since May 2018. When people did receive assistance to bathe some gave variable feedback about the quality of this support. One person told us, "My washing is not so good. I have a shower every morning but it's not as good as it should be." This demonstrated people did not always receive support that met their needs.

People's preferences were not always respected. One person had stated they did not wish to be supported by a particular staff member and their care plan had been updated to reflect they would not be supported by them. However, a behavior record completed a month after the person's request documented they had 'refused' this staff member's support. This could have been avoided if guidance in their care plan had been followed to reflect their wishes. This did not respect the person's preferences.

Overall, care plans contained an adequate level of detail about people's needs and most were up to date. However, staff did not always use these to inform care and support. One member of staff told us, "I feel the care plans are informative and any change is handed over. We do not read them regularly but I have looked at them if I have time." Another member of staff told us, "The care plans are ok but we do not look at them much." This placed people at risk of inconsistent support.

There was a risk people may not receive the support they needed when their needs changed. Three people had slips of paper in their care plans which stated, 'Not for hospital admission unless fracture or laceration.' There was no further information about this in their care plans and staff told us they were "not sure" what this meant. The lack of personalised information in care plans placed people at risk of receiving support that



did not meet their needs.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems and processes in place to deal with complaints; however, feedback from people living at the home and their relatives was mixed. Some people told us they would feel comfortable making a complaint; however, one person told us, "If you complain they can turn against you." We also received feedback from a family member that complaints were not always resolved to their satisfaction.

In addition, we received concerns from some staff that people's complaints were not always treated fairly. Several staff told us they felt that complaints from people living at the home were not taken seriously. One member of staff told us, "I know residents have complained in the past. I have felt that some people's complaints have not been taken that seriously due to their mental health." Another member of staff told us, "I feel sometime if a resident says something it is not taken as seriously as it should." There had been several complaints and concerns recorded since our last inspection, the majority of which were from people's relatives. Some complaints were still under investigation and others were recorded as being resolved. There were no complaints recorded from people living at the home. This meant systems to handle complaints were not always effective.

People were provided with some opportunities for social activity. Overall, feedback from people was positive. One person told us, "There are plenty of activities but I haven't done many recently. I also read the paper and watch the TV a bit. Four people mentioned a very recent boat trip that they had greatly enjoyed. Some mentioned going out with a staff member to do little bits of shopping or going out with their family for meals and outings. The provider employed two activities coordinators who worked Monday to Friday. They worked with people to understand what was important to them and this was then included in their care plan. They attended 'residents' meetings' to discuss activities and events. They did a mix of group activities and spent time with people on a one to one basis. They told us, "There's lots of different activities that take place here; we have a dog show every year, it's just a bit of fun with relatives bringing their dogs in, but people really enjoy it." They told us some people had expressed a desire to go to the seaside. To make this an inclusive event they had organised to bring the seaside to Seely Hirst House, with sand, paddling pools, 'proper' fish and chips and an ice cream van.

Despite the above we observed and several staff commented that people sometimes lacked meaningful occupation, particularly when the activity coordinators were not on shift. One member of staff told us, "(There are) no activities at the weekend, most residents get up sit in the lounge then have lunch sit in the lounge then tea then bed, there is no stimulation through the day." Another member of staff said, "I feel a lot of the residents get left in the lounge with not much going on." A third member of staff commented, "I think the problems are more staff and more activities to make it more person centred. Rather than just help with living." During the late afternoon and early evening of our inspection several people spent a significant amount of time unoccupied in communal areas and we saw that much of the communication with staff, although friendly, was functional and task focused. This meant people were not always provided with opportunities for meaningful activity.

People were provided with caring and compassionate support in their last days of life. People had been given the opportunity to discuss their wishes for the end of their lives and this was recorded in their care plans. When people were coming towards the end of their lives there were plans in place to ensure their wishes were respected and to make sure they got appropriate support and pain relief. The acting manager told us people's families were provided with a room, food and drink to enable them to stay with their loved

one in the last few days of life. They said, "We encourage families to treat it as their home at these times." The home had a memorial wall and a remembrance table to remember people and staff who had passed away at the home.

People's diverse needs had been identified and accommodated. People's religious and spiritual needs were identified and recorded. For example, people who wished to practice their religion were provided with opportunities to do so at the home or in local places of worship. One person told us staff supported them to attend their chosen place of worship and a minister sometimes visited them at the home. The activity coordinator told us they read from a religious text to one person each day. They said, "That's all they want from me. They don't want big activities but just doing that one thing for them makes a big difference." There was a person living at the home whose first language was not English, the acting manager told us two staff spoke in their native tongue and often assisted the person to make their needs known.

We spoke with the acting manager about how they ensured they met their duties under the Accessible Information Standard (AIS). The AIS ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. Although the acting manager was not aware of the AIS they told us they considered people's communication and information access needs as part of care planning and delivery. They gave examples, such as, supporting people with regular sight and hearing tests and the use of photos and signage to meet the needs of people with dementia and memory loss. They advised us they would find out more about the AIS and take further action to meet people's needs if required.

## Is the service well-led?

### Our findings

Systems to monitor and improve the quality of the service were not effective. Although there were processes in place to monitor the quality and safety of the service these were not comprehensive. For example, although there were cleaning schedules and an infection control audit in place, these did not cover moving and handling equipment or the medicines room. Consequently, it had not been identified prior to our inspection that these areas were not sufficiently clean.

Audits conducted by the provider were not regular or effective in identifying areas of concern. Records showed the provider had planned to conduct monthly audits of the home. In the 10 months prior to our July 2018 inspection only one 'monthly audit' had been conducted by the trustees. This was not sufficiently regular to monitor the running of the home.

The record of an 'unannounced monthly audit' by the provider in May 2018 commented on the physical appearance of one person and included details of a short conversation with them. A discussion with a relative of this person was also recorded. Two members of staff were interviewed and a visual inspection was conducted which concluded the home was bright, clean and fresh smelling. No documentation or records were reviewed as part of the audit, no issues were identified and consequently no action plan was developed. This failure to ensure robust and effective audits were undertaken meant shortfalls were not identified prior to our July 2018 inspection.

Effective action was not taken to improve practice based on learning from incidents and feedback from people and their relatives. During our inspection we found a body map from late 2017 which documented that a person's watch had been left on their arm all night leaving a red mark. In early July 2018, we were informed of concerns that this person's watch had been placed incorrectly on their arm leading to a red mark. At the time of our inspection the acting manager told us action was underway to improve staff practice in relation to this and other issues. However, following our July 2018 inspection we were informed of a further incident where the person's arm was marked due to the incorrect placement of their watch. This demonstrated a failure to take effective action to improve the quality of care and support provided at Seely Hirst House.

Accurate and up to date records were not kept of people's care and support. At 12.30pm during our inspection we reviewed fluid records for five people. None of these records had any entries for the day of our inspection. At approximately 14:15pm we saw two staff trying to recall what support had been provided to people that morning. The staff member was trying to recall this from memory but was unable to fully recall details, frequently stating, "I'm not sure. I will have to check with [another member of staff]." The failure to ensure records were complete and up to date meant the provider was unable to demonstrate people had received the care and support they required.

People's relatives were not always provided with the information they needed to enable their involvement in decisions about their relative's care and treatment. During our inspection we spoke with a person's relatives who shared concerns that they had not been informed about an allegation of neglect involving their relative, who lacked capacity in relation to some aspects of their care. The acting manager was aware of the

allegation, but had not communicated this to the person's family. They did not find out about the incident until they received a call from a social worker investigating the case. This meant they did not have all the information required to ensure they could make informed decisions about the care and support of their relation.

Systems to ensure care plans were updated as a result of incidents were not effective. Behaviour records had not been effectively reviewed and learning from these had not been incorporated into care plans. Consequently, two people's care plans were not accurate or up to date. This failure to ensure accurate and up to date records were kept of people's care and support placed them at risk of receiving inconsistent and potentially unsafe support.

Sensitive personal information was not stored securely. Information about people's continence needs, routines and other information about people's care and support needs were left in communal areas. For example, we found records on a piano in the communal lounge. This posed a risk that sensitive personal information could be accessed by other people or visitors to the home.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always feel valued or involved in the running of the home. Regular staff meetings were held and records showed these were used to communicate change and news to the staff team and address areas for improvements. Staff confirmed that they attended meetings but told us they felt their feedback and suggestions were not always listened to. One member of staff told us, "We have supervisions and had meetings in the past but we are not involved in any change." Another member of staff said, "We have team meetings where we can put our opinion forward but I don't feel they take it on board." Several staff told us they did not feel valued by the provider. One member of staff said, "Not really, I feel that the care staff are pressured to work when they are short staffed and I know paper work is important but they push lots of silly paperwork. I feel if they worked with us and not just tell us more things to do people would feel more valued." Another member of staff commented, "Not really, mainly because staff morale is low because we are always short and staff are staying over their shift time and we do not get any recognition for this."

Although staff told us they would whistle blow to external agencies should they have concerns about the care and support provided at Seely Hirst House, this was not promoted by the provider. Records of an audit conducted by the provider noted that whilst staff morale was improving there were some staff who were 'intent on finding negatives,' the report concluded that management should 'be careful not to take some staff comments at face value.' Furthermore, following our inspection visit we received concerns that the provider had advised staff not to whistle blow to external agencies, such as CQC. This meant whistle blowing concerns may not be raised or acted upon appropriately.

We checked our records, which showed the provider, had not notified us of all events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. We had not been notified of some allegations of abuse referred to the local authority safeguarding adults team. We discussed this with the management team who assured us this was a mistake and said they would ensure notifications were made in the future.

There was no registered manager in post at the time of our inspection. There had been some recent changes in the management team at Seely Hirst House. Overall people, their relatives and staff said these changes had a positive impact on the atmosphere and running of the home. One person told us, "Yes I think it is well led. It runs smoothly." Another person said, "I am happy here. If I wasn't I'd go somewhere else." People and

staff told us the acting manager was friendly, approachable and supportive. A member of staff said, "Yes, they are approachable. They are always around through the day, I feel if I needed them they would be there." However, we received some feedback from people's relatives and staff that additional management cover was needed at weekends to ensure people received the same quality of care seven days a week.

Throughout our inspection the management team were responsive to feedback and took action to address areas of concern, ensuring immediate risks were reduced. After our visit the acting manager provided us with an action plan based upon the feedback we provided.

People were given the opportunity to provide feedback about the running of the home. One person told us, "I go to the residents' meetings. I think they are good and our suggestions are listened to." Another person commented, "There are regular residents' meetings and ideas get taken on. Recently there was a tutorial on different foods like pureed or cut up food." There were monthly meetings for people living at the home and their relatives. These were used to discuss areas such as food, events, housekeeping and planned maintenance. Quarterly meetings were held for people's relatives. People, visitors and health and social care professionals were also encouraged to give feedback in regular surveys and using online forums.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the home and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care  People were not always provided with person centred support that met their needs and reflected their preferences.  Regulation 9 (1)

### The enforcement action we took:

We imposed a condition requiring the provider to implement and report on an audit system to ensure the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  People were not protected from risks associated with their care and support or the environment.  Regulation 12 (1)

### The enforcement action we took:

We imposed a condition requiring the provider to implement and report on an audit system to ensure the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes to ensure the safety and quality of the service were not effective.  Confidential information was not stored securely.  Effective action was not taken in response to known issues.  Accurate and up to date records of care and support were not always kept.

**The enforcement action we took:**

We imposed a condition requiring the provider to implement and report on an audit system to ensure the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There were not always enough staff available to meet people's needs and ensure their safety.</p> <p>Regulation 18 (1)</p>

**The enforcement action we took:**

We imposed a condition requiring the provider to implement and report on an audit system to ensure the safety and quality of the service.