Seaswift House

Seaswift House Residential Home

Inspection report

Sea Hill
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Seaswift House Residential Home (hereafter known as Seaswift House) is a residential care home in the town of Seaton in walking distance of the town and seafront. The home is three converted town houses linked together and provides personal care for up to 15 people aged 65 and over. At the time of our inspection there were 14 people using the service, 1 of these people was in hospital at the time of our visit.

People's experience of using this service and what we found
People and relatives said they felt safe at the service and complimented the staff team and the engagement with the registered manager and provider.

We found the quality and safety of the service had deteriorated since our last inspection in September 2022 and some previous breaches of regulation remain along with additional breaches. The provider's systems and processes designed to identify shortfalls, and drive improvement had not been fully completed and remained ineffective.

Risks to people were not always assessed, monitored, mitigated or managed effectively. Care plans were not always put in place to guide staff to mitigate risks. This meant staff were not always aware of the risks to people they supported.

People's needs were not fully assessed to ensure care was appropriate for their needs and they were not always supported by enough staff to support them safely.

Due to staff shortages the registered manager had needed to undertake care duties to support people. Improvements were made after the inspection visit and additional agency staff were requested to cover staff shortages and enable the registered manager to be able to undertake managerial responsibilities.

People's medicines were not safely managed to ensure people received their medicines safely.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the care plans and systems in the service did not support this practice.

The recruitment process in place had improved. The registered manager had a checklist in staff recruitment files to ensure they had the required recruitment checks in place.

The registered manager and provider were very visible at the home and spoke with people and relatives on a daily basis. They were open and honest and recognised that some areas of the home's management process had deteriorated, which placed people at risk. As part of the local authority Provider Quality Support Process (PQSP) they were working with the local authority to manage those risks and keep everybody

informed.

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 last rating for this service was requires improvement (published 28 October 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
Seaswift House came out of the local authority whole service safeguarding process on 29 September 2022 and received ongoing support from the local authority Quality Assurance and Improvement team in a Provider Quality Support Process (PQSP).

As part of this process the local authority Quality Assurance and Improvement team and Eastern Care Services team visited the home at the beginning of January 2023. They shared worrying information about what they had found at their visit, which raised significant concerns. The areas of concern they raised were around risk management, staffing, medicines, safe working practices and escalating concerns. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Requires improvement to inadequate based on the findings of this inspection.

We 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.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to staffing, safe care and treatment, consent, safeguarding people from abuse and improper treatment and good governance at this inspection. 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.

Follow up
The provider has informed us they will be submitting an application to CQC to deregister the service. We will work with the local authority to monitor progress during the home closure. We will continue to monitor information we receive about the service, which will help inform our next action.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Seaswift House Residential 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 Health and Social Care Act 2008.

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
Two inspectors carried out this inspection.

Service and service type
Seaswift House is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Seaswift House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they had given notice to the

provider and would leave the service on 26 February 2023. The Care Quality Commission had received an application from the registered manager to deregistered prior to the inspection. They were deregistered on the 24 January 2023.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
In September 2022 the provider had been placed into the local authorities Provider Quality Support Process (PQSP). As part of this process they received support and visits from the local authorities Quality Assurance and Improvement team and Eastern Care Services team. We were copied into the reports from these visits and reviewed this information.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
During our visit to the home we observed the care and support people received in the main communal areas. We met all of the people who lived at the home and spoke with 7 of them about their experience of living at the service. We also spoke with 2 visitors.

We spoke with the registered manager, 1 of the partners, 2 team leaders, 1 carer and the cook. We also spoke with an agency worker.

We reviewed 5 people's care records and 7 people's medicines records. A variety of records relating to the management of the service were reviewed, these included recruitment records, staff rotas, fire documents, quality monitoring and quality assurance records. We also looked at the provider's service improvement plan.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At the inspections in January 2022 and September 2022 the provider had not ensured people received care and treatment in a safe way. Risks had not been assessed and actions not taken to mitigate risks. 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.

Although some improvements had been made in relation to fire safety at this inspection, we identified concerns which placed people at risk, therefore the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

- People were not protected from risks associated with their individual needs. Risks were not always assessed, monitored, mitigated or managed effectively. Where risks to people had been identified, the provider did not ensure staff had adequate information or measures in place to effectively prevent and protect people from these risks. For example, 1 person could become distressed and could pose a risk to themselves, other people using the service and staff. As a result, they needed almost 1 to 1 care and support. Although incidents of this nature had been recorded, staff did not have clear guidance about how to identify possible triggers or support needed for people who expressed feelings of anxiety or distress.
- Risk assessments and care plans for 2 people admitted to the service in December 2022 and January 2023 had not been developed. There was limited information about their complex care needs, including mobility, dietary and emotional needs. This placed them at risk of receiving unsafe support.
- One person was at risk of leaving the service unaccompanied. Information had not been clearly recorded about this risk and guidance for staff about how to deal with the situation was limited. This placed the person at risk.
- One person required a diet to help control their diabetes, not all staff were aware of this. There was no risk assessment or care plan to ensure the correct level of care was provided. We saw staff gave the person food which should be avoided with the person's underlying condition.
- Two other people's care records we looked at required reviews to ensure they were accurate and that the care needed was delivered.
- Some people required their weight to be monitored; we found 1 person had not had their weight monitored and recorded within the stated timescale recorded in their care records. This meant there could be a delay in responding to any changes in the person's health needs.
- At the last inspection we saw that some staff were living in a self-contained flat on the top floor of the home. The registered manager said they would complete a risk assessment to look at any potential risks this posed to people. At this inspection the registered manager said they had not completed a risk assessment.

Systems and processes were not sufficient to demonstrate risk was identified, assessed and well-managed.

This exposed people to the risk of avoidable harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the day of the inspection visit we discussed with the provider and registered manager concerns that agency staff did not have access to people's computerised care records. The registered manager put in place an agency folder with a copy of the front sheet from the computerised system for each person. This enabled agency staff to be able to access information about people's needs and risks to help promote safer care. The week following the inspection the registered manager confirmed agency staff had access to the computerised care system.
● We saw improvements had been made to the fire safety at the home. An external company had completed a fire risk assessment on 17 October 2022 and no significant concerns had been identified.
● Everybody at the home had a personal emergency evacuation procedures (PEEPs) which detailed the support they needed in the event of an emergency to keep them safe.

At the inspections in January 2022 and September 2022 we found the provider had not ensured people's medicines were safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we identified medicines were not being safely managed which placed people at risk, therefore the provider was still in breach of regulation 12.

Using medicines safely
● Poor oversight and management of people's medicines put them at risk of not receiving their medicines safely and as prescribed.
● Medicine administration records (MAR) handwritten by staff were not clear and did not always give details about the medicines people required. These entries were not signed and did not have a checking signature which was in line with the provider's policy. Staff had completed a daily audit of medicines document the week of our visit which required staff to record that all handwritten entries had two signatures. They had not identified this was not the case and therefore this daily audit was not effective.
● Four new people did not have a photograph in the medicine folder alongside their MARs to help staff identify them to ensure the right person received the right medicines.
● Staff were not recording the quantity of medicines people had when they arrived at the home. This placed people at risk, for example, 1 person had no signatures on one day on their MAR, and we could not be assured they had received these medicines.
● Protocols and instructions for the use of 'when needed' medicines (PRN) were not in place for 2 new people who had recently come to the service. This included one medicine which required extra security and could place the person at risk of receiving the medicine unsafely.
● The system to ensure people had their medicines in stock was not effective. We saw 1 person had run out of their medicine. This meant people were placed at risk of not having the medicines they were prescribed.
● It is good practice to have a staff signature sheet showing all the signatures of staff administering medicines. This is so it is clear who administered a medicine. The provider had a medicine signature sheet but not all staff who administered medicines were recorded on this sheet.
● The registered manager and senior staff had not completed a full medicine audit since our last inspection. This meant they had not used a monitoring system to ensure medicines were being safely managed.

The provider had not ensured the safe management of medicines which placed people at risk. This exposed people to the risk of avoidable harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff member administering medicines during our visit, spent time with people and gave them their medicines in a caring way.
● Arrangements were in place to ensure a person who went on a visit with a relative, still received their prescribed medicines.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA.
● Some people were living with dementia and did not have mental capacity assessments completed to ensure decisions made were in their best interests.
● There was no evidence in the care records to show relatives and professionals had been appropriately consulted with as part of any 'best interest' decision. There was no information in care plans to guide staff about how they could assist people to make some decisions for themselves.
● The Registered manager had completed an electronic support plan audit for 1 person in October 2022. They had identified a mental capacity assessment was needed as this person required a pressure mat as they entered other people's rooms at night. We were told by the registered manager at the inspection this had not been completed.

The provider had not ensured they had the relevant consent for people's care and treatment in line with the Mental Capacity Act 2005. This exposed people to being unlawfully deprived of their liberties. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We met with 2 people who had restrictions placed on them and were being illegally deprived of their liberty as no authorisations were in place. Staff said they were unable to leave the building unless accompanied by another person or a staff member.
● Records showed, these restrictions had not been discussed and agreed with the person's family or legal representative. There was no mental capacity assessment in place specific to this decision; no best interest meeting decision or DoLS authorisation in place for these 2 people. This meant the service did not have relevant assessments and authorisations in place to restrict people's freedom and were doing so unlawfully.

The provider had not ensured they had lawful authority to deprive people of their liberty for the purpose of receiving care or treatment. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspections in January 2022 and September 2022 there were shortfalls in staff recruitment procedures which was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, enough improvement had been made and the provider was no longer in breach of regulation 19.

Staffing and recruitment

● There were not enough staff to support people safely. There were 3 care staff on duty during the day and evening at the home and 2 staff on duty at night. Since the last inspection, the service has had several new admissions. Some of these people had complex needs and required a lot of staff time to keep them and others safe. One person required staff to be with them almost on a 1 to 1 basis, we saw some lovely interactions with this person. However, this meant there were only 2 care staff available to support the other 12 people at the home.

● Staff said there were not always enough staff to spend time with people and staff sickness and absence had an impact on this.

● At times we observed there was little staff presence in the communal areas. We saw and heard minor altercations between people who invaded other people's personal space.

● Due to staffing levels, there were no planned or spontaneous activities to ensure people had meaningful and stimulating engagement. The provider was advertising for a part time activities co-ordinator.

The provider had not ensured there were sufficient suitably experienced staff to support people safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The recruitment process in place had improved. The registered manager had a checklist in place in staff recruitment files to ensure they had the required recruitment checks in place.

● The recruitment process included obtaining references and a Disclosure and Barring Service check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● People said staff were available when needed and that call bells were responded to quickly. Comments included, "They never take too long" and "The girls come reasonably quickly to me; there are no problems there."

● The provider and registered manager acknowledged difficulties managing staff absence's and vacancies whilst ensuring people's needs were being met. The registered manager explained they had needed to cover senior care staff roles and work on the floor daily to cover shifts. We discussed with the provider working with care agencies to get experienced senior care staff cover, to support the home and registered manager at this difficult time. The provider confirmed at the end of the inspection visit that they had contacted 3 care agencies to request senior care staff to undertake shifts at the home.

● The provider had used agency care staff to cover a number of shifts to try and maintain staffing levels. The provider had only felt safe allowing 1 agency staff member to work on any shift alongside their own staff members. This had not ensured there were always enough staff on duty. The week after our visit the registered manager confirmed they had changed their approach and had consistent agency staff working at the home, on 1 day there were 4 agency staff working at the home to ensure there were sufficient support to meet people's needs.

At the last inspection in September 2022 people were not always protected from the risk of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, enough improvement had been made and the provider was no longer in breach of regulation 12 in regards to infection prevention and control.

Preventing and controlling infection

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Improvements were seen regarding the cleanliness of the home. The provider had appointed an

additional housekeeper to clean people's bedrooms, so care staff were not required to do the cleaning.
● Visitors commented on the cleanliness of the home. Comments included, "Yes, it is always clean here, as an outsider I can't fault this place. I have no concerns" and "Always clean here…no nasty smells…they all work very hard."
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● In line with current government guidance the home was open to visitors. There were no restrictions to movement around the home.
● Visitors confirmed they were able to visit with no restrictions. Comments included, "I come very often to see (person). No restrictions to visiting."

Systems and processes to safeguard people from the risk of abuse
● People and relatives confirmed they felt safe at the service. People's comments included, "They are all lovely …very jolly. They are careful with me" and "All very nice." A relative commented, "When I go home, I have no worries about (person)… is safe here and in the right place and is being looked after very well."
● Although not all staff spoken with had completed safeguarding training since starting work at the service, they understood their responsibilities to report any related concerns. Staff were confident the registered manager would take appropriate action to protect people from harm.

Learning lessons when things go wrong
● Opportunities to learn from incidents and accidents were missed. There was a lack of detail and analysis of falls, accidents and incidents to help identify trends and learn lessons to prevent reoccurrence. Large sections of accident and incident records had not been completed; for example, if there were any contributing factors or possible interventions to prevent future falls and injuries.
● The registered manager and provider said their monitoring of incidents had fallen behind due to staffing shortages, which meant the registered manager had been working more on the floor supporting the delivery of care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

At the inspections in January 2022 and September 2022 the provider had failed to ensure systems and processes were effective in monitoring the safety of the home and were operated effectively. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider remains in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had not maintained compliance in meeting regulations over a period of time. Quality assurance measures were not being used effectively or regularly to monitor the quality of the service to drive improvement.
- At the inspection in September 2022 the provider had implemented improvements with the support of the local authority Quality Assurance and Improvement team and a specialist nurse and occupational therapist. They had worked together to develop a service improvement plan (SIP) setting out the areas which required improvements. At this inspection we found the SIP had not been acted upon and improvements we had previously seen had fallen behind.
- The provider had quality monitoring systems and processes in place. However due to staffing vacancies and absences the management team said they had not had time to complete these and told us they were 3 months behind with their audits. This meant some issues we had identified in the safe section of this report had not been identified by the provider. For example, medicines safety, risk assessments and mental capacity assessments.
- There was no evidence of effective actions being taken or any analysis of incidents or concerns to identify areas for improvement or to prevent incidents reoccurring. Accidents and incidents were not fully analysed for themes to identify how to put improvements in place.
- We found inconsistencies and gaps in record keeping. Some people's care records were not complete and not kept in a contemporaneous way. The variability in the quality and consistency of record keeping meant we could not be confident people were receiving the care and treatment they required. The gaps in record keeping meant people were at increased risk.
- The staffing rota did not always reflect accurately the staff on duty.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued 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

● The provider and registered manager told us they had been dealing with staffing concerns at the home. The provider said some staff were causing a 'caustic atmosphere' at the home which was causing additional challenges. They said along with the registered manager they were trying to protect people from the negativity occurring at the home.

● Along with the registered manager, staff had been undertaking additional care shifts to provide care and support to people. Staff we spoke with said it had been a difficult time and were unsure about the home going forward as they were aware the registered manager was leaving.

● The rating from the previous inspection was on display at the home as required.

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; Working in partnership with others

● The provider and registered manager shared information with people and their relatives about what had gone wrong at the home. Throughout the inspection process they were open and honest and kept the local authority and CQC informed about the future of the home. After the inspection they made the local authority and CQC aware they would be closing the home and would work with all concerned to ensure people found a new home.

● The provider had made all necessary statutory notifications to the CQC. This is a legal requirement placed on care providers. Receiving notifications enables the CQC to monitor regulated services and identify where there may be potential risks which need to be addressed.

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

● The registered manager and provider were very visible at the home and spoke with people on a daily basis. However, residents' meetings had fallen behind. Visitors confirmed they could speak with the registered manager and provider when they visited. One visitor said, "I can speak with them if I had any concerns, but I don't. I see them when I visit. I could speak with any of the girls if I had a worry".

● The provider asked staff to complete a questionnaire. They had received 2 responses which were mainly positive. They told us they would be collating the responses and sharing the actions they were taking with staff.

● The provider showed us they had survey questionnaires ready to be sent to people and relatives to ask their views.