Prime Life Limited

Seacroft Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Seacroft Court Nursing Home is a residential care home that provides personal and nursing care and support for up to 50 older people and/or people living with a dementia. At the time of the inspection there were 44 people living in the service.

People's experience of using this service:

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were enough care staff to meet people's needs. The cleanliness and internal environment required improvement and would benefit from a review of housekeeping staff hours and duties. The environment was tired, and several areas of the service were unclean. We saw several areas of risk in the grounds and in their current state were not a safe area for people to access.

Staff had access to policies and procedures on safeguarding and whistleblowing and knew how to identify signs of abuse and raise their concerns within the service. People told us that they felt safe.

People received their medicines from staff who were assessed as competent to do so. However, safety measures did not always identify when a medicine was out of date, we acknowledge that the registered manager removed an out of date topical medicine when we brought this to their attention.

People had their care needs assessed, but care was not always delivered in accordance with best practice guidelines.

Staff received training pertinent to their roles. New staff undertook a comprehensive induction.

People were supported by a range of health and social care professionals and records were kept for all visits and consultations.

People were provided with a balanced and nutritious diet. Special diets were catered for and staff supported people who required assistance to eat and drink.

Internal signage and the information shared on notice boards did not always reflect the needs of a person living with dementia. People's confidential information and personal details were not stored securely. The office door was left open when unoccupied and personal care files were accessible.

People were cared for by kind and caring staff. However, we saw little evidence of staff integrating with people. There was no designated activity time. Most people were not engaged in meaningful activities or

social interaction and sat in silence in the lounges. People did not always receive care that met their needs and preferences.

People had access to information advocacy services and the provider's complaints procedure.

The registered manager is a visible leader, has an open door and is approachable. Staff report that they feel supported.

The registered manager completed regular audits. However, these did not identify or action the failings we found on our inspection.

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

The provider met the characteristics of Requires Improvement. This has changed from a rating of 'Good' at the last inspection in January 2016. More information about this is in the full report.

Rating at last inspection: Seacroft Court Nursing Home was last inspected on 05 January 2016 (report published11 March 2016) and was rated as 'Good' overall.

Why we inspected: This was an unannounced planned inspection based on our previous rating.

Follow up: We will continue to monitor intelligence we receive about Seacroft Court Nursing Home until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Requires Improvement

Is the service effective?

The service was not always effective.

Requires Improvement

Is the service caring?

The service was not always caring

Requires Improvement

Is the service responsive?

The service was not always responsive

Requires Improvement

Is the service well-led?

The service was not always well led

Requires Improvement

Seacroft Court Nursing 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector and an assistant inspector on day one and by a single inspector on day two.

Service and service type:
Seacroft Court Nursing Home is registered as a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection

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

Notice of inspection:
We did not give the provider notice of this inspection.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection:
During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us. We spoke with the registered manager, the quality matters nurse coordinator, the quality matters manager, a registered nurse, two care staff, the cook, the head housekeeper and five people who lived at the service. We also spoke with three visiting relatives and a visiting healthcare professional.

We looked at a range of records related to the running of and the quality of the service. These included risk assessments, three staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance processes that the registered manager had completed. We also looked at care plans and daily care records for 10 people and medicine administration records.

After the inspection
We looked at training data and quality assurance records that the provider sent us. In addition, the registered manager sent us photographs from a recent social event.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Preventing and controlling infection

- We found serious risks in the designated smoking room and our findings contradicted the guidance in the provider's fire safety policy. Following our inspection, we shared our concerns with Lincoln Fire Safety Team.
- Our concerns included curtains and chairs that were not fire retardant, burn marks on the Formica topped table and hard surface floor and an open mesh waste bin that would not contain a fire if lit cigarettes were placed in them by accident. The door from the dining room to the smoke room was not a fire proof door. We also found that some people smoked in this area unsupervised placing themselves and others at risk. Since our inspection the provider has removed the curtains and replaced the furniture with approved fire retardant chairs.
- The fire door in the basement laundry was propped open when the laundry was unoccupied. There was a risk that if a fire broke out in the laundry room that it would quickly spread throughout the basement area.
- The summer house in the garden was unlocked, and the door was ajar. There were cigarette ends on the wooden floor and over flowing ashtrays on the wooden veranda. Inside we found a butane gas cylinder, mattresses for collection, several partially used pots of paint and a mobility scooter from a person who had passed away a few months ago. This area was also used to store continence aids. There was a risk of fire in this area due to people and staff smoking in an area that housed combustible and flammable materials.
- People were at risk of burns or scalds from the food service trolley. This was situated in the dining room and was switched on. It was very hot to touch and there was no protective guard around it. This area is used throughout the day, as some people preferred to sit in this area rather than the lounge. The area was not always supervised by care staff. We found similar concerns with a portable heater in the smoking room that was unguarded and hot to touch.
- The sliding door on the lower section of the food service trolley was broken and the lids on the upper section were soiled. We brought this to the cook and the registered manager's attention. The kitchen assistant removed the lids to wash them. However, we noted that they used their tunic to protect their hands from burns, and not the oven gloves provided for this purpose.
- There was a designated locked COSHH cupboard in the basement where cleaning aids and detergents were securely stored.
- There was a small kitchen area in the dining room. This was used for care staff to make hot and cold drinks

for people and their visitors and for staff to store food items for personal use. We noted that the standard of hygiene in this area was poor. The sink was soiled and there was a build-up of limescale around the taps. The work surface was damaged and the seal around the sink was broken. The inside of the fridge was dirty with food spills and there were open containers of soft drinks. We found a build-up of food debris on the floor under the base units and boxes of single use aprons and napkins were stored on the floor. The poor standard of cleanliness in this area put people and staff at risk of cross contamination.

● Other areas of the service were unclean and we found dirty toilets, commode chairs and bathing equipment.

● We saw where a person was being barrier nursed to prevent the risk of cross infection to others, that staff and visitors to their bedroom had access to protective gloves and aprons. However, the bin for their disposal, situated outside the bedroom was not suitable for clinical waste, was manually operated and did not have a special bin liner. This meant there was a risk of cross infection to staff and visitors accessing this area.

● We saw six metal cages containing soiled linen [that were collected twice a week] and four large unlocked clinical waste bins in the grounds. These were accessible to people who used the gardens and there was a significant risk of cross contamination.

● The registered manager was unaware of the safety risks and fire hazards that we identified on our walk around the service.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to policies and procedures on safeguarding and whistleblowing and knew how to identify signs of abuse and raise their concerns. However, the telephone contact details provided were internal and did not include the local authority safeguarding helpline.

● People and their relatives told us that Seacroft Court was a safe place to live. One person's relative said, "She knows everyone, even when she is confused, and they know her."

● People who lived in the service had a personal emergency evacuation plan (PEEP) in place. This provided staff with information on how to safely evacuate the person to a place of safety in an emergency.

● We saw up to date records were kept on the maintenance of fire safety and utility systems such as electrical items and gas appliances.

● Two housekeepers were the designated Infection Prevention Control (IPC) Link Practitioners. They attended all IPC Link meetings planned by the local authority IPC Team. The link practitioners were responsible for sharing up to date guidance and research with their colleagues.

● The laundry was well laid out with a dirty and clean flow system to prevent the risk of cross contamination.

● The home had been awarded a five-star rating from the local environmental agency.

Staffing and recruitment

● The registered manager was not a registered nurse and was not supported by a deputy manager, clinical lead (nursing) or a head of care. The registered manager had been actively seeking to recruit a full-time clinical lead to post for eighteen months. This meant that nursing and care staff did not have the benefit of a clinical lead to turn to for advice and support. There was a risk that this could impact on the standard of care people received.

● Another significant staffing challenge was that, apart from one member of permanent registered nursing staff, the service was dependent on agency nurses to cover all day shifts. One agency nurse had worked continuously in the service for 18 months.

● Some staff told us that there were enough staff to care for people's care needs, but they were unable to

spend time chatting with people and they found this challenging as there were no activity staff to support them.
● The cleanliness and environment would benefit from a review of housekeeping staff hours and duties to ensure that the cleanliness of the service were always maintained to an acceptable standard. A senior member of staff told us that the two senior housekeepers worked together, and the two less experienced housekeepers worked without supervision and support. This could impact on the less experienced staff developing their skills to provide a high standard of cleanliness.
● The registered manager and housekeeper told us that the level of maintenance support they received was inadequate and did not meet the needs of the service. A maintenance person employed by the provider visited the service once a week, but was unable to complete all the outstanding jobs.

The provider had failed to employ sufficient numbers of suitably qualified staff to take the clinical lead to supervise care staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed. We saw evidence that similar safety checks had been carried out for agency staff also. In addition, safety checks were made to ensure that registered nurses were registered with the Nursing and Midwifery Council.
● There were enough care staff on duty to meet people's personal care needs and care staff were supported by a registered nurse and senior member of care staff during the day. The registered nurse on night duty also took on the role expected of a senior member of care staff. For example, they administered medicines to both nursing and non-nursing residents. There were 24 people with nursing needs at the time of our inspection. A senior member of staff told us that a senior carer on night duty would be a support to care staff to help with their professional development and supervision.

Using medicines safely
● People received their medicines from staff who were assessed as competent to do so.
● However, we found that medicines were not always managed safely. We noted that one person had a topical application, a skin cream that expired in 2014 and had another skin cream prescribed to another person who lived in the service. These errors had not been identified by nursing or care staff. We brought this to the registered manager's attention, who arranged for the skin creams to be disposed of.
● When a person had their medicines administered covertly, that is hidden in their food, we found that all safety checks had been undertaken and the person's GP, pharmacist and close relative had been involved in the decisions. There were clear written instructions on how the medicines should be administered.
●Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer their medicines safely.

Learning lessons when things go wrong
● Some areas for improvement were shared with the registered manager on day one. When we returned on day two, we found that action had been taken to address some of our concerns. For example, we observed that the curtains in the smoke room had been removed and a fire blanket was in place; out of date skin cream had been disposed of and pressure relieving mattresses were checked to ensure they were at the correct setting. The registered manager told us that they planned to de-brief all staff after our inspection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Adapting service, design, decoration to meet people's needs

- There were several wall mounted notice boards sharing topical health and wellbeing information with people their visitors and staff. For example, we saw information on dignified care, effective handwashing practices and how to make a complaint. However, it was evident that people had not been involved in the content, location and accessibility of these notice boards, as they were sighted above eye level and information contained jargon and was not presented in an easy to read format.
- We observed that some windows in the location had recently been replaced as part of a refurbishment programme. However, we also saw several windows where the seal had blown, and the windows were misted-up inside making it difficult for people to clearly see through them.
- Several areas of the service required attention. For example, a broken lock on a bedroom door and damaged bedroom furniture. There was a risk that people could be harmed by damaged and broken fixture and fittings. The signage on two downstairs toilet doors recorded both vacant and engaged. This meant that people would not know when the toilets were free to use.
- We walked round the grounds and found that they were hazardous and in need of urgent attention. Empty bird feeders and dogs' toys were lying on the ground and were a trip hazard. These environmental hazards were accessible to anyone using the grounds.
- In addition, people were at risk of injury from other hazards, such as uneven and missing paving stones, a broken picket fence, a rust damaged drain cover and a broken garden table. There was no visible signage to alert people and their visitors to the hazards in the grounds.
- Overall, the grounds were an unsuitable space for the people who lived in the service to access. They did not reflect their mobility, safety or recreational needs and preferences.

The provider had failed to ensure that the premises and equipment were properly maintained. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Although people had their care needs assessed, care was not always given in line with best practice guidance. For example, on day one we noted that one person was on an air-flow pressure relieving mattress. The person was frail and weighed less than 60 kilograms. However, their mattress was set to deliver pressure suited to a person weighing between 130 and 160 kilograms. This meant that instead of the mattress relieving pressure on the person's skin they were put at risk of damage to their skin from the increased

pressure. This was not an isolated incident. The registered manager requested that a district nurse visit to check the mattress settings. ● On day two the district nurse had not yet visited to re-set the mattresses. We asked the registered manager to follow up as we were concerned that people were at increased risk of developing pressure damage. The district nurse visited later that day and carried out a check of all air flow mattresses.

● One person's relative told us how staff had helped their loved one make the transition from another home into Seacroft Court and said, "She has settled in really well and has her own routine."

● When a person moved into the service for a short-term respite stay they also had their needs and preferences assessed. We noted that one person was aiming to return to their own home with support when fit enough to do so.

Staff support: induction, training, skills and experience

● People were cared for by staff who were enabled to develop their knowledge, skills and experience. Staff attended mandatory training such as fire safety, food hygiene and safe moving and handling. In addition, staff were provided with training relevant to their roles and individual needs of the people in their care, such as the care of a person living with dementia.

● Newly appointed staff undertook the Care Certificate, a 12-week national programme that covered all aspects of health and social care.

● Some staff had taken on lead roles relevant to their area of interest and the needs of people who lived in the service. For example, health and safety, continence and medicines. The registered manager had the lead role for dignity, dementia, mental capacity and safeguarding.

Supporting people to eat and drink enough to maintain a balanced diet

● People and their relatives told us that the food was good and that they were given a choice. One person's relative shared with us how staff had worked with their loved one to encourage and support them to eat when they did not want to and said, "Very particular about her food, was used to her own cooking. Was offered all sorts but wasn't eating much. Staff encouraged her to sit at the table with others. They were very good with her, but she lost weight. The GP and dietician were involved. She has now gained weight and eats and drinks."

● People were provided with a nutritious, varied and balanced diet that suited their needs and preferences. There was an option of a cooked breakfast and we saw plenty of hot and cold drinks and snacks served throughout the day.

● Kitchen and care staff had access to an up to date record of individual food likes, dislikes, allergies and special diets. All dietary needs were cross referenced with individual care plans.

● People with swallowing difficulties had their food specially prepared. Some had their food mashed and others had it pureed or liquidised. To ensure their meal was always visually appetising, individual food items were served individually on their plate.

● Care staff sat beside people who required assistance or supervision to eat their meal.

● People at risk of dehydration or weight loss had their food and fluid intake monitored.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;

● People were supported to access healthcare and social care professionals such as their GP, optician and dentist when required. In addition, some people had regular support from their district nurse, speech and language therapist and/or their community psychiatric nurse. The chiropodist visited the service twice a month. Records of all consultations were maintained with clear detail of treatments given and any necessary follow-up advice. Two people were in-patients in the local general hospital at the time of our inspection.

● Some people required support from the community nursing team. In order to promote continuity of care a community nurse and healthcare support worker had been allocated to Seacroft Court. A visiting healthcare professional told us that care staff followed through on any advice given.
● Care staff shared information at shift handovers about individual care needs and overall wellbeing to maintain continuity of care. Essential information was recorded on a daily handover sheet to ensure staff were up to date with any changes to a person's overall well-being or care needs. For example, their nutrition or mobility needs. Staff members said that handovers had improved and they like the new handover information sharing sheet.
● People also had a handover sheet to be used when they moved between services or went to hospital. We saw this contained information that would help people who did not know them understand and meet their health and care needs.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that where people were being lawfully deprived of their liberty that staff were following the principles of the MCA.

● Where a person had appointed a lasting Power of Attorney (LPA) to act on their behalf when they were no longer able to make decisions for themselves a copy of the document was kept with the person's care file.
● When a major decision, such as permanently moving into the service had to made, a best interest meeting was undertaken with the person and their family or representative. Records showed that staff were acting in the person's best interest.
● We saw that staff had sought support from an Independent Mental Capacity Advocate (IMCA), appointed by the local authority MCA and DoLS team. The IMCA represented the person, to act in their best interest as they had no-one else to support them and were unable to communicate their wishes.
● We found evidence in the care files that people gave their consent to care and treatment.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

- We saw that care records, personal files and archived documents were not always stored securely. On day one of our inspection we observed that the office door was consistently left open when not in use. Personal care files and other confidential information was accessible. We brought this to the registered managers attention who said they would remind staff to ensure the door was closed and locked when the room was not in use. On day two, we again found the door unlocked when not in use. In addition, we found several boxes of archived personal care records, dating back at least two years in a ground floor storeroom. The digital lock on the door was broken. A senior member of staff told us that the lock had been broken for at least a month. However, this had not been escalated to the registered manager or maintenance person to be repaired. The registered manager arranged for the lock to be replaced.
- The food service trolley was situated in an accessible position in the dining room. There was a list with the names of people who had any food allergies or special dietary needs attached to the front of the trolley. This was clearly visible to anyone passing through the area. We brought this to the registered manager's attention. The registered manager had the list removed.
- Our observations meant that peoples' confidential information was not stored in compliance with the Data Protection Act and the General Data Protection Regulations (GDPR).

The provider had failed to ensure that confidential information was securely stored. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People who were able and their relatives told us that they were well looked after. One person's relative said, "Really nice staff. Can't sing their praises enough. Anything we ask, they do. They go above and beyond. They have done so much." A visiting healthcare professional told us that staff were kind, caring and helpful and added, "They are just caring people."
- Peoples' individual religious, cultural and spiritual beliefs were respected by staff and some people received a regular visit from their priest or vicar.

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

- People were enabled to access an independent advocate if they wished. An independent advocate is a lay person, independent of the service and offers support and acts as voice for people who are unable to make decisions for themselves. For example, to make the decision to move into the service permanently.

Information leaflets on advocacy services were available at reception.

● People and their relatives were encouraged and enabled to personalise their bedrooms with familiar items from home, such as family photographs, ornaments and soft furnishings.

● We saw that people were supported to express their views and this was recorded in their care file. For example, one person who was no longer able to express their views verbally had written, "I think the same way, I'm just unable to convey my thoughts easily." We saw that clear information to help staff communicate with them effectively was recorded in their care plan and staff had also used picture cards and drawings.

● One person who was cared for in bed in a sea facing bedroom, had their bed positioned in such a way that they could not look out of the window at the view. The person told us that it was their desire to look at the sea. This was shared with the registered nurse on duty.

Respecting and promoting people's privacy, dignity and independence

● At lunchtime we observed care staff take meals to people in their bedroom. Meals were not presented in a dignified manner. One member of care staff took a plate of food and a knife and fork to a person in their bedroom. They did not carry their lunch on a tray or offer them a napkin or condiments. Another staff member carried the meal for two people on the same tray, they did not offer condiments. We noted that neither member of staff knocked on the door or announced their entry when entering their bedrooms. This meant that staff did not always treat people with dignity or respect their individual needs and lunchtime service was a task to be done.

● People who took their meals in the dining room were offered a single use tabard to protect their clothing from spills. In addition, people with dexterity problems had a plate guard to support them to eat their meal with minimum difficulty.

● The dining room had recently been decorated and people had been involved in choosing the wall colour and bunting.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People did not always have choice and control over some aspects of their care. For example, the registered manager told us that people could have a bath or a shower whenever they wanted one and the service did not keep a bath or shower list. However, we noted that the daily handover sheet recorded the names of six people who had been selected to have a bath or shower that day. People therefore received care that was task orientated and at a time suitable to the needs of care staff and the routine in the service.
- We observed little evidence that people were encouraged, supported or enabled to take part in meaningful and/or stimulating activity. People had their past hobbies and interests recorded as part of their pre-admission assessment. However, these were not maintained once the person moved into the service. Our observations conflicted with the guidance in the provider's "activity and meaningful occupation policy" which stated that activities should be accessible and people living with dementia should have social and emotional stimulation.
- Late morning on day one there were 10 people sat in the main lounge area. Most people were asleep or staring vacantly in front of them. Loud music was playing, and it was not age appropriate. We had difficulty speaking with people and staff in this area because the music was so loud. A member of care staff turned down the volume and changed the radio station to gentler music. However, people were not asked if they would like their choice of music to be played.
- It was the provider's policy not to employ activity coordinators. The registered manager took responsibility for arranging singers and an instructor to lead a weekly armchair exercise class. However, we found that members of staff were not empowered to lead people to follow their individual hobbies, interests and past-times. Staff told us that people were not supported to take part in hobbies and pastimes.
- Day one of our inspection was the 75th anniversary of D-day. Most people who lived at Seacroft Court would have been alive in 1944 and several had served in the armed forces in later years. The service had no activities in place to mark this historic occasion. The registered manager told us that some people had watched coverage of the anniversary on television the previous day.

The provider had failed to ensure that people received care that met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care plans were easy to follow and were written in a clear and concise manner. Care plans were person centred and people and their relatives were involved in planning their care.
- The registered manager had introduced "the resident of the day" initiative. Each person had a day once a

month that was centred on them. All their risk assessments and care plans were reviewed and updated by their key worker or named nurse.

● Once a month the service had access to a mini-bus owned by the provider. The registered manager told us that up to ten people and care staff could take trips out to the local town or tourist attractions. The previous month people visited a local nature reserve for lunch. People living with reduced mobility were able to participate as the mini-bus could safely accommodate two wheelchairs.

● Other events were organised, such as visits from Shetland ponies once a month. We looked at photographs of these visits and found that people engaged with the ponies and really enjoyed their visits.

● A relative told us that they could take their loved one out at any time and said, "I take her out to [named nearby towns] for lunch."

● Preparations were underway for the grand opening of the "Residents' Retreat" on 15 June. This was in response to male residents saying that they would like to go to the pub. The registered manager had contacted local businesses for donations of food, drink and bar furnishings to change the use of a sitting room into pub.

● Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers

Improving care quality in response to complaints or concerns

● We looked at the comments, compliments and complaints records. One verbal complaint had been received in the last 12 months and was responded to appropriately.

● Information on how to make a complaint to CQC was on display. However, people and their relatives were not provided with information on how to make a complaint to external agencies such as the local authority, or the local government ombudsman.

End of life care and support

● We spoke with the relative of a person who had recently passed away. They shared with us that they were full of praise for the care staff had given to their loved one.

● The registered manager was involved in an NHS project to introduce a new emergency treatment assessment record called Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). ReSPECT was being trialled in Lincolnshire and would eventually be rolled out nationally. The document was person centred, it involved the person and key people in the person's life including their family and healthcare professionals. Where a person was admitted to hospital or transferred to another care setting the form went with them. ReSPECT replaced previous do not resuscitate orders and advanced decision to refuse treatment. It meant that all emergency care wishes were recorded in one document.

● We noted that people's wishes for care at the end of their life was recorded in their individual care files. For example, one person expressed that they did not want to go into hospital to die and another person had recorded the songs they wanted played at their funeral and a message for their family, "Stick together or I'll come back to haunt you".

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care

- Prior to our inspection the provider sent us a Provider Information Return (PIR). This provided us with some key information about the service, what the service did well and improvements the provider planned to make. We found that some of the information in the PIR was not relevant to the needs of the people who lived at Seacroft Court or had not been implemented since the PIR was last submitted in January 2018. For example, it mentioned the roll out of a new medicines administration system that the registered manager was not familiar with.
- The provider's brochure, "Enjoy life at Primelife" were available in the reception area. The brochure contained information about the environment provided in a care setting for people living with dementia. However, it did not accurately reflect the service. For example, we read, "All bedroom doors are painted a different colour, have own door knocker and a personalised identity frame outside to aid recognition." There were no bedroom doors fitting this description.
- Following our enquiries, we noted that the information contained in the PIR, provider's brochure and statement of purpose were generic to all locations registered with the provider and had not been tailored to the needs of individual services. Their contents focussed on the achievements and aspirations of the provider and was not specific to developments in the service.
- Regular audits and quality visits were undertaken as part of the providers governance system by the registered manager, the quality matters nurse coordinator and the quality matters manager. We saw that key areas of non-compliance identified each month had not been actioned. There was no recorded evidence that the provider or their representative had visited the service in the last 12 months.
- Once a month the registered manager collated information on accidents and incidents within the service. These were analysed for trends, such as the cause and any action taken. However, these did not address the areas of concern that we identified on our inspection. Lessons were not being learnt and the provider was not making improvements to the quality of care in response to the weaknesses identified.
- The quality governance framework failed to identify and act on the concerns we found on our inspection.

Failure to provide systems and processes that assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff received an annual appraisal and regular supervision. Team leaders were empowered to undertake supervision with other staff. For example, the head house keeper carried out supervision with the other housekeepers. We noted that topics covered were relevant to the needs of the service, such as team work and safe moving and handling practices. Staff were given feedback on their performance through an annual appraisal.

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

● Staff spoke positively about the support they received from the registered manager. One member of staff said, "[Registered manager] is very good and approachable, but up against it with the bosses and staff sometimes. Tries to be nice to everyone." Another staff member told us that the registered manager was supportive and added, "But she doesn't seem well supported."

● Relatives told us that they found the registered manager approachable. One relative said, "[Registered manager] treats mum like one of the family. We can have a laugh. She is approachable and empathetic. It helps me leave mum. If I had to rate the home I would give it twenty out of ten."

● It is a legal requirement that a provider's latest CQC inspection report is prominently displayed. This is so that people living in the service and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed near the main entrance and on the provider's website. In addition, the registered manager's certificate of registration was on display.

● The manager and provider had submitted notifications that they are required by law to submit to CQC.

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

● People and their relatives were invited to regular meetings with the registered manager. The head cook also attended these meeting to discuss the menu choices with people. We read the minutes from the recent meeting held on 25 May 2019 and saw that people and their relatives had a say. Topics for discussion included a recent barbeque, the planned opening of the Retreat Bar and suggestions for trips out. The registered manager also shared the report from local authority quality visit.

● Meetings were held with all staff from all areas and disciplines within the service. We saw the minutes from recent meetings with registered nurses, care staff and night staff. The topics discussed were relevant to the care that people received from each staff group. We noted that staff had a voice at these meetings. However, when we spoke with staff we found that concerns raised were not always actioned. For example, staff were concerned about the lack of activities and stimulation for people and also that there was nowhere to record when a person had their bowels opened.

Working in partnership with others

● The registered manager and their team worked in partnership with their local clinical commissioning group and the local authority contracting team

● The provider was a member of the Lincolnshire Care Association (LinCA). LinCA provides members with regular newsletters, workshops and networking to enable them to keep up to date with current best practice initiatives. The registered manager attended these meetings.

● The registered manager was trying to build links with businesses in the local community to help raise funds for the comfort of people who lived at Seacroft. In addition, local schools had been approached inviting them to visit and spend time with people in the service. However, at the time of our inspection, no schools had accepted the invitation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure that people received person-centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to ensure people received safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to ensure that premises and equipment were clean and safe to use

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure that the service was well-led.