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Seacliff Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Seacliff Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided.

Seacliff Care Home is registered to accommodate up to 24 people. At the time of our inspection there were 17 older people living in one adapted building in a residential area of Bournemouth.

People's experience of using this service and what we found
People told us they were happy living at Seacliff Care Home. However, we identified several shortfalls and governance systems were not robust enough to keep people and staff safe. Infection control procedures were either not in place or robust enough to fully protect people. Fire safety concerns had been identified but actions were not taken.

Potential risks to people's health and welfare had not been consistently assessed. There was not always guidance for staff to mitigate the risks. Records of the care people received were not always accurate or complete. Medicines were not always managed safely. Testing had indicated a risk of Legionella in the water system. The home was working in partnership with the environmental health office and an external water specialist to mitigate the risk.

There were enough staff on duty and people told us they attended to their needs promptly. Staff told us they were happy working at Seacliff and had confidence in the newly appointed management of the home. Staff were recruited safely, and the necessary checks had been made. Safeguarding procedures were in place and followed, staff told us they were confident the manager would follow up on concerns raised.

Staff, people and their relatives felt involved in the home. However, this was reduced during the pandemic and alternative arrangements had been made for contact and visiting. The home had links with various organisations but the manager said this had reduced during the year but was hoping to build on these in the future.

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

Rating at last inspection
The last rating for this service was good (published 26 July 2018).

Why we inspected
We received concerns in relation to fire safety, infection control, medicines and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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 Seacliff Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and treatment of people and the management of the service 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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Seacliff Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors 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.

Service and service type
Seacliff Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have had a manager registered with the CQC since August 2020. A registered manager is someone who is registered with the CQC. 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
This inspection was unannounced.

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 the fire service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key

information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, manager, activities, housekeeper, senior care workers, care workers and the chef. We made general observations throughout the inspection.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at five staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further information from the manager and provider, and this was supplied to us promptly. We sought feedback from one professional who regularly visits the service but we did not receive a response.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. The provider had a process in place to welcome visitors which was displayed in the entrance to the home. This included applying Personal Protective Equipment (PPE), temperature checks and health screening questions. However, when we arrived, we were not subjected to any of these safety checks nor was there any equipment to carry out the checks present at the entrance.
- The manager told us there was a designated area to put on and take off PPE. However, there were no stocks of PPE or disposal bins in this area. Staff told us that they enter the home and go to the office at the rear of the home to get the PPE and thermometer to check their temperature. This meant staff were entering the home without the necessary checks and without PPE. The manager arranged for PPE to be stocked in this area before we left.
- Staff did not always use PPE correctly. We observed three staff members routinely wearing their PPE incorrectly throughout the day, by exposing their nose from their face mask. We observed this practice around the home and when they were attending to people's needs.
- Prior to a self-guided tour of the home we were not informed that a person was isolating in their room due to possible exposure to Covid-19. There were no separate PPE stocks, separate disposal, signage or separate toilet facilities for this person in order to ensure a barrier from others.
- Social distancing was not practiced or promoted within the home. People were seated in lounges next to each other as chairs were positioned together in all lounges and place settings together in the dining room. We spoke with the provider who told us they would arrange for social distancing to be promoted within the home.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection prevention and control was effectively managed. 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.

The provider responded immediately during and after the inspection. This included ensuring that stocks of PPE were placed at the entrance to the home and speaking with staff.

- The provider had a process in place and the home was participating fully in whole home testing of people and staff.
- The provider had an infection control policy in place, and this was up to date.

Assessing risk, safety monitoring and management

● People did not always have risk assessments in place to ensure they were kept safe. The correct procedures were not always used to reduce risk of harm. This is because they were either not in place or they did not relate to the individual person. Examples were where a person had bed rails in place and where people with underlying health conditions may be at a higher risk from Covid-19.

● Risks in the environment had either not been recognised or did not have a robust assessment of the risks. For example, there were two oil filled radiators being used in communal areas which were hot to touch which could have cause injury. We alerted the manager and they told us that they did not have a risk assessment in place and removed them from use.

● Where risks were identified action was not always taken to address the risks. For example, the provider commissioned a risk assessment of fire safety within the home on 7 October 2020 this identified a number of serious and urgent risks. Action was not taken until after an unannounced visit from the fire service on 18 November 2020. The provider had to address one risk immediately and had been given a short timescale for completion of 12 additional points.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks to people were identified, reduced and effectively managed. 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.

The provider responded to some of the concerns immediately during and after the inspection. This included working with an external company to address all of the points raised by the fire service.

Using medicines safely

● People did not always receive their medicines safely. We observed staff administering medicines for more than one person from the main office and taking them to people in their rooms. This meant that an error could be made as the staff member had to rely on their memory to give the right medicines to the right person.

● Liquid medicines and prescribed creams did not always have the opening date on them. This meant that their effectiveness could be affected.

● Where people were prescribed medicines that they only needed to take occasionally, guidance was not in place for staff to follow to ensure these medicines were administered in a consistent way. This meant that there was a risk a person may not receive their medicines when they needed them.

● There were gaps in the medicines fridge temperature records which meant it was not possible to evidence that medicines had always been stored at the correct temperature.

We found no evidence that people had been harmed however, systems were not effective to ensure medicines management was safe. 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.

The provider responded immediately during and after the inspection. This included speaking with staff and given us assurances that safe procedures would be followed.

Staffing and recruitment

● The home had a recruitment process in place. However, where people had been promoted within the home there was no assessment of recruitment decisions made. The manager told us that promotions had occurred under previous management and they were addressing this.

● New staff to the home were subject to various checks. These demonstrated that staff had the skills,

knowledge and character needed to care for people. Staff files contained appropriate checks, such as references, health screening and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with people in a care setting.

● There were enough staff on duty. People told us that staff were there when they needed. Some of the comments we received were; "There are enough staff for my needs. No problems at all". "They check on me frequently, it reassures me".

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

● People and their relatives told us they were happy with the care and support they received at the home. Some of the comments we received were; "It's very comfortable here, I do feel safe". "Oh yes, it's very nice here". "I am quite content here". "My relative [name] is settled, safe".

● Staff had received training in safeguarding people. Staff told us how they would recognise signs and symptoms of abuse and who they would report them to both internally and externally. Staff told us they would not hesitate to report concerns and had confidence in the manager to follow them up.

● Accidents and incidents were recorded. This included an analysis by the manager once a month to identify any trends and patterns. The manager told us they used this to learn.

● The provider told us that they are keen to take any feedback from the inspection to learn and change practices at the home for the better.

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

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

- Quality assurance systems did not always operate effectively. Audits were not present, incomplete or robust, these systems had not identified the shortfalls found during the inspection.
- Where audits had been completed the information contained within them was not always accurate. For example, the fire exit section of the health and safety audit stated that all exits were operable, but this was not the case as identified in the full fire audit and risk assessment completed on 7 October 2020.
- Actions from audits were not always carried out. For example, one action of purchasing and displaying essential fire safety signage was repeated for the past 11 months. The provider told us this was the responsibility of the company who dealt with fire safety, but this had not been followed up.
- People's care records were not always up to date or complete. This meant they could not be sure that people were receiving the care they needed. The manager told they had identified this and would be working to address this.

We found no evidence that people had been harmed however, the provider had failed to ensure governance systems were operating effectively to ensure risks are managed, people are protected from harm and the service improves. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they were seeking an external consultant to support with a full home audit and creation of an action plan.

- The home did not have a manager registered with the CQC since August 2020. The provider told us they were not yet been in a position to put forward an application but was aware this was a condition of registration and would seek to address this as soon as possible.

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

- Staff told us they were happy working at Seacliff Care Home. Some comments were, "We are like one big family". "I am happy to work at Seacliff". "We work together, I am happy".
- There have been recent changes to the management of Seacliff Care Home. The provider told us they had a new management team in place and would give them support to succeed. Staff, people and their families

were positive about these changes. Some of the comments we received were; "I can speak to the manager [name] about anything and they will sort it". "I feel supported". "The manager [name] is alright they listen and help". "The manager [name] is good with the residents, they interact with them. Not all managers do that".

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

- The manager understood the requirements of the duty of candour, that is, their duty to be honest, open and apologise for any accident or incident that had caused or placed a person at risk of harm. They told us the circumstances in which they would make notifications and referrals to external agencies and showed us records where they had done this.
- The home had made all statutory notifications as required by law. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, their families and staff told us they felt involved in the service. The involvement had been reduced somewhat in light of the Coronavirus pandemic and limited visiting. The home had made alternative arrangements to enable people to meet with their loved ones, using the garden.
- The home had regular staff meetings and twice daily handovers. Staff told us they were informative and gave them a good understanding of what people needed for the day.
- The home had links with various organisations but due to the pandemic had not interacted with them as they once did.
- The manager told us that they had a good working relationship with health professionals and records showed regular positive contacts. We did seek feedback from health professionals but did not get a response.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes were not in place to provide safe care and treatment to poeple in regards infection control, medicines, risk management and fire safety.

The enforcement action we took:

Served a warning notice telling the provider where they had breached the regulations and by what date they must be compliant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were either not in place or robust enough to have oversight of the service.

The enforcement action we took:

Served a warning notice telling the provider where they had breached the regulations and by what date they must be compliant.