Buckinghamshire County Council

# Seeleys House Short Breaks Centre

## Inspection report

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20 February 2018
21 February 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 19, 20 and 21 February 2018. It was an unannounced visit to the service.

Seeleys House Short Breaks Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 home provides respite care. This means people often stay one or two nights. The numbers of people staying at the home during the course of inspection ranged from four to five. Seeleys House Short Breaks Centre is registered to care for up to 12 people and supports people with a learning disability and or physical disability.

We previously inspected the service on the 27 and 28 June 2017. We found breaches of the Health and Social Care Act 2008 (HSCA). We found people who used the service were not protected against the risk of unsafe or inappropriate care in regards to management of risks. We found people were at risk from the management of their medical condition, fire and medicine management. This was because records relating to the care and treatment were not accurate and up to date. We also found people were not supported in line with the Mental Capacity Act 2005 (MCA), as the service did not always assess people's ability to consent to care. We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served two warning notices to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be compliant was 02 October 2017.

We found the service had complied with the warning notice in respect of the MCA. However we found on-going concerns about records management. We found a number of records were not accurate; there was a potential people could come to harm because of this. We found the provider had not made sufficient improvement in regards to record keeping.

We also served the provider with requirement notices for beaches of a further five regulations of the HSCA. We had concerns about people's safety, as risk assessments did not always provide staff with sufficient information on how to minimise risks to people. There was a lack of systems in place to manage situations where potential abuse was identified. We found equipment was not always safe to use. We found the provider was not always operating in an open and transparent way. We asked the provider to send us an action plan detailing how they intended to improve the key questions safe and well-led to at least good.

At this inspection we found improvements had been made in safeguarding people from abuse, the use and maintenance of equipment, and the openness and transparency of the provider. For instance, the provider ensured they notified CQC of certain events when they were legally required to do so. However we found on-going concerns about the risk management within the home. We found potential risks to people were not always identified and managed. For instance there had been fire doors that had not closed routinely since

November 2017. Although this had been reported and some work carried out to rectify the problem. On the inspection we found some fire doors were still not shutting fully.

The service did not always recognise practise that had the potential to restrict people's freedom. We have made a recommendation about this in the report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ' Seeleys House Short Breaks Centre' on our website at www.cqc.org.uk.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We observed positive interactions between staff and people. We saw people were smiling and laughing with staff. Staff were able to share people's likes and dislikes with us. It was clear the staff had developed a good working relationship with people.

We noted there had been an improvement in the access people had to activities of their choice. Relatives told us people had been to the seaside for a day trip, for picnics and had been supported to go to the local shops.

The service worked well with external health and social care professionals to ensure people's needs were met.

The new management had stabilised the staff team and had developed accountability and professionalism to the home. They had sought feedback from people and their relatives on how the service could develop. The provider's senior management team demonstrated a commitment to improving the service.

This is the second consecutive time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## 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.

People's likelihood of experiencing injury or harm was not always reduced because risk assessments did not always identify areas of potential risk.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

### Is the service effective?

**Good**

The service was effective.

People were encouraged to make decisions about their care and day to day lives. People were encouraged to be independent.

People were cared for by staff who were aware of their roles and responsibilities.

### Is the service caring?

**Good**

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with dignity and respect.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People did not routinely have care plans in place which reflected their current level of need.

People had access to a range of chosen activities within the home and the local area.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Records relating to people's care and treatment were not always up to date. Risk assessments was not always in place to support staff to provide safe care.

The service had developed and had benefitted from an experienced manager who had stabilised the home.

# Seeleys House Short Breaks Centre

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection site visit took place on 19, 20 and 21 February 2018 and was unannounced; this meant that the staff and provider did not know we were visiting. On day one of the inspection the team consisted of one inspector and a specialist advisor who is a nurse with experience of working with people with a learning disability. On day two of the inspection the team consisted of the same inspector, a second inspector and two experts 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. One expert joined the inspectors at the service and the other expert made telephone calls to people and their relatives. On day three the team consisted of the same two inspectors as day two.

Before the inspection the provider completed a Provider Information Return (PIR). We used information the provider sent us in the PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with four people staying at the home who were receiving care and support, we spoke with 10 relatives. While at the home we spoke with the registered manager, two of the provider's senior managers and nine care staff. We reviewed six staff recruitment files and 12 care plans within the service and cross referenced practice against the provider's own policies and procedures.

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 talk with us.  We looked at other records held by the provider which included incident forms and health and safety reports.

We also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who stayed at the home.

Requires Improvement

# Is the service safe?

## Our findings

At the previous inspection carried out on 27 and 28 June 2017 we found people who received care and treatment were not protected from avoidable harm. We found multiple breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not always protected from risk associated with their medical condition, risk of fire and medicine management. We issued the provider with a requirement notice to improve. The provider sent us an action plan detailing how they would ensure improvements were made. At this inspection we checked what action had been carried out and if people were protected from avoidable harm.

We found some improvements had been made in protecting people from harm. For instance, the safe management of medicines had improved. Better systems were in place to ensure people were given the right medicine. The service had worked with the clinical commissioning group (CCG) pharmacist. A number of recommendations had been adopted by the service. However we found on-going areas which required improvement. For instance one person who was staying at the respite unit was prescribed thickener for their drinks. This was following a speech and language therapist review, which highlighted a need to reduce the risk of choking. There was clear guidance for staff on how the persons drinks should be thickened. However when we spoke with staff and observed practice we found not all staff were following this guidance and the person had been given a drink which could have caused them to choke as it was too thin. We immediately addressed this with the registered manager who advised the care plan and communication with the staff would be updated. We also observed the thickening agent was left in the main kitchen which people had access to. We asked staff about this. One member of staff told us "It's only stored in the kitchen when [Person's name] is staying". However the person was not staying in the home on the day we found the thickener in the main kitchen. Another member of staff told us "It should be kept in the store cupboard (not accessible to people) as [Name of person] could end up pouring it in his tea thinking it was sugar."

At the last inspection we noted the service had been issued a notification of fire safety deficiencies by Buckinghamshire Fire and Rescue (BFR). At this inspection we checked if this notice had been complied with. We received confirmation from BFR they were satisfied the areas identified in their notice had been improved. However we noted fire doors had been reported as intermittently faulty since November 2017. Although we acknowledged the lead for health and safety had reported these to the provider's property management team. We noted work had been previously completed to rectify the issues highlighted, however when checked the fire doors at the inspection some did not fully shut. We spoke with representatives from the provider who expressed concern that previous remedial action had not resolved the issue. Following the inspection we received confirmation from the provider that appropriate action would be taken to protect people from the risk of fire.

At the last inspection we noted the service did not routinely protect people from the risk of harm due to their medical conditions. In particular, for people with a diagnosis of diabetes or people who required nutrition through a percutaneous endoscopic gastrostomy (PEG). A PEG is a way of passing food, medicines and fluid into the body via a tube which is passed through the skin into the stomach. At this inspection we checked if improvements had been made to ensure staff had the required information to provide safe care to people

and prevent harm.

We found some improvements had been made, however we found on-going concern. At this inspection we found there was insufficient or inconsistent information about people's medical conditions. We found one person who was newly diagnosed with diabetes did not have any risk assessment in place to advise staff of what to do if their blood sugar levels were elevated or low. Another person who was a diabetic also did not have a risk assessment in place to advise staff on how to manage raised blood sugars. This meant there was a potential for people's health to deteriorate as staff did not know when they should be concerned about a person's blood sugar levels.

One person who stayed at the respite unit had a PEG in place. However the risk assessment around the management of the PEG did not provide accurate information to staff on how to minimise harm to the person. This meant there was a risk staff could harm the person if they followed the guidance provided.

These were all continued breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection carried out on 27 and 28 June 2017 we found people who received care and treatment were not protected from avoidable harm in regards to the use and maintenance of equipment. We found multiple breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made to the management and maintenance of equipment used by people. Two members of staff had been identified as a lead for health and safety and took a proactive approach to managing health and safety issues. We spoke with one of the members of staff responsible for reporting health and safety concerns. We found them to be committed to improving safety within the building.

Each person had a personal emergency evacuation plan in place and staff were aware of how to support people in the event of an emergency.

At the previous inspection carried out on 27 and 28 June 2017 we found people who received care and treatment were not protected from the risk of abuse. We found multiple breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. Staff had understood training provided and were able to recognise potential abuse. We noted the provider had reported incidents to the local authority when required. The service had a safeguarding procedure in place. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. Staff had access to the local safeguarding team contact details. Staff informed us that they would contact that team or the Care Quality Commission (CQC) if management did not report safeguarding concerns. One member of staff told us "I would speak to the team leader if I had a concern or I would phone safeguarding." Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority and also their requirement to report this to CQC.

We found some improvements had been made to the environment. At our last inspection the key question about infection control was optional. Since November 2017 CQC needs to look at the control measures in place to prevent infection spreading. We spoke with a staff member who was working as a housekeeper. This worker was joint lead for infection control. They told us "[name of colleague] and me are down for infection control. I only took that role on last week." We asked if they had taken infection control training. They replied "I haven't done it here." They had done this with a previous employer but had been in post at the service since May 2017. When we reviewed daily cleaning schedules we saw that these had not always

been completed. These were not completed on 17th and 18th February 2018. On 19th February 2018, we saw that the only items on the schedule that had been ticked were for emptying bins in three toilets and hovering the carpet. Staff who were responsible for food preparation had received appropriate training. We spoke with the registered manager about the improvements required around housekeeping and infection control.

People were supported by staff with the appropriate experience and character to work with people. The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Staff we spoke with who had been recently recruited told us they felt the recruitment process was thorough.

Relatives told us they had confidence that enough staff were on duty to ensure safe care of their family member. We spoke with the registered manager about how they ensured enough staff were on duty. They informed us they had introduced a pre-admission meeting. This meeting was arranged prior to a person staying at the respite unit. It considered risks to the person and if staff had the appropriate skills to support the person. For instance, if a person needed support via a PEG the provider ensured staff had received the training to support them. The registered manager had a system in place to monitor staffing levels. On day one of our inspection a person was unexpectedly staying at the service for an extra night. We observed the registered manger and senior staff assess if there were enough staff to meet the person's needs. Staffing levels and deployment were also monitored by the provider through their quality audits.

The provider had systems in place to recognise and respond to when the service provided was lacking. Staff we spoke with understood the need to raise safety concerns to the management. Staff told us they had confidence their concerns would be dealt with by management. We noted the provider had arranged a number of meetings with key people in their organisation to discuss how they could improve following specific incidents. We found the provider and registered manager committed to improving the safety of each person who used the service.

Incidents and accidents were recorded and the registered manager monitored any trends to aid learning from the events. The provider looked at accident and incidents when it conducted monthly audits.

Good

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the previous inspection carried out on 27 and 28 June 2017 we found people who received care and treatment were not supported in line with the MCA. We found multiple breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action to ensure improvements were made. We issued a warning notice to the provider. The provider needed to be compliant with the Regulation by the 2 October 2017. At this inspection we checked if improvements had been made to ensure people were supported in line with the MCA.

We found some improvements had been made, we found evidence the provider had considered if people were able to consent to care and treatment. If a person was identified as not having the mental capacity to make a decision we saw the provider followed the guidance of the MCA and recorded a 'best interest' decision. However this was not evident for all the people we looked at. We discussed this with the registered manager. They told us staff had received training in the MCA and team leaders were carrying out decision specific assessments. Staff demonstrated they had a better understanding of the MCA. One member of staff told us "The Mental Capacity Act sets out how to make a decision on someone's behalf using the five principles. Most importantly it makes it clear that everyone should be deemed as having capacity unless it is established that they don't."

The registered manager had made appropriate DoLS referrals to the local authority. We found a number of people who stayed at the home had an authorised DoLS in place. The registered manager had a system in place to monitor applications made and what the outcome was. The registered manager was aware of the need to report decisions made on DoLS applications to CQC.

We found restrictive practices were in place. For instance one person's transport risk assessment stated that child locks should be used; however this was not considered by the service as restrictive and was not included in a DoLS assessment. Another person was supported to wear cycling shorts over their continence aid to prevent them accessing the aid. There was no guidance or assessment to demonstrate this was in the person's best interest.

We recommend the service ensures paper work completed complies with the code of practice for MCA.

Prior to people staying at the home, the provider ensured an assessment of their needs was carried out. Where people required specific equipment this was provided. For instance, one person required an epilepsy

sensor to support them to receive the right care if they had an epileptic seizure. Another person had been referred to the community occupational therapy team for an assessment. Following the assessment new equipment had been identified. The registered manager told us the person's admission had been suspended until the equipment was in place. The registered manager demonstrated a commitment to providing safe care to people.

The home had forged links with the local GP practice to ensure people's healthcare needs would be met when they stayed at the home. The registered manager had worked with the local GP to draw up a protocol. On the second day of the inspection we noted a GP had been called as concern was raised about a person's health. The person had been prescribed antibiotics.

The home actively sought support from external healthcare professionals to help them care for people safely. We noted people had been seen by speech and language therapists as well as district nurses as examples.

Staff at the home worked together and with external bodies to ensure people's care was co-ordinated. For instance there was regular communication about people who attended local day services. We overheard a number of telephone calls being made to family members, day services and healthcare professionals to communicate any changes identified in people's care.

People were supported by staff who understood their role and responsibilities. A new member of staff told us "My induction was completed by a member at Seeleys very effectively done as it gave me the confidence to support the service users and to provide good quality of care." Another member of staff told us "My induction was very good as I have learnt a lot about the clients."

Following initial induction training staff were provided with on-going support in the form of one to one meetings and an annual appraisal of their performance. Staff told us they had regular meetings. A staff member we spoke with told us they had two supervisions since November 2017 which was consistent with the records. There were systems in place to monitor the support given to staff.

Staff told us they were happy with the level of training provided. One member of staff told us "The training is regular and of a high standard" another member of staff told us "Yes we have excellent training here to enable me to carry out my job role." Since our last inspection the provider had invested in a robust training programme for staff. Training for staff at the service was co-ordinated by the local authority. The registered manager told us that "Masses of training" was available. They told us that "Last week staff had person-centred care planning training." Staff completed mandatory training and updates including safeguarding, moving and handling, fire safety and infection control. Some training such as moving and handling was delivered practically. Training updates were taken regularly. The service had identified when staff members were overdue for mandatory training. Some staff had taken the Care Certificate, which is a set of fifteen standards to underpin the practice of workers in social care. A staff member we spoke with told us they had completed training including moving and handling, and medication administration training. They told us that training was signed off by the registered manager or operations manager. Relatives we spoke with told us they felt staff were trained to support their family member.

People were supported with their nutritional needs. Staff had a good understanding of people's likes and dislikes for food. This was detailed in their care plan and the kitchen staff had information about people's dietary needs. We did note that some of the information was in need of updating. We spoke with the registered manager about this who confirmed this was in hand. We observed the planned meal on day one had been altered to accommodate a person who was staying. We observed two meal times. We found staff

supported people in a safe and professional manner. Where a person required one to one supervision and support with their meal, we observed this was provided. Information on healthy diet options was available to people and staff. One person told us "I like the food. I look at the pictures. I have sandwiches." A pictorial menu was displayed in the dining area for people.

We found many improvements had been made to the environment. The home was welcoming and accessible. We noted each room had been decorated in a different style. Relatives we spoke with were pleased with the changes made to the home. One relative told us "I think the place suits the people who go there. It's nice and roomy and airy. I've been into the bathroom once but I like the bright curtains in the lounge." One person staying at the home told us they liked the flowers and had "Some on the wall in my bedroom."

Good

# Is the service caring?

## Our findings

People were supported by staff who demonstrated kindness and a commitment to providing a high quality service. We observed many positive interactions between staff and people staying at the home. One person told us "It's nice" at the service. We received positive comments from all the relatives with spoke with. They were all complementary about the staff describing them as "caring."

We observed staff had a good understanding of people's emotional needs. On day one of our inspection we observed a handover meeting in which staff were discussing how they could support a person. The person was not expected to stay at the home. Staff arranged for the person's usual routine to be followed. This decreased the person's anxiety levels. We noted when the person returned to the unit they were relaxed and content.

One relative told us how the service had supported them and their family member who stayed at the service. The family had been through a difficult time. The relative told us "The team were fantastic," they went on to say the staff had been "Unbelievably kind and sensitive."

People were respected by staff; we observed staff speaking to people in a professional and appropriate manner. Staff addressed people by their preferred name. One person who was staying at the unit on day three of our inspection liked to have their soft animal toys in a basket, so they could carry them around. The staff very quickly arranged this when the person arrived at the home. We could see from the person's face they were happy about how the staff had supported them.

Staff supported people to be involved in decisions about their care. We observed staff talked to people about what they wanted to do, and how they wanted to be supported. People who stayed at the home had a wide variety of communication styles. Staff understood how people communicated. One person signed to communicate when they were happy or sad. Staff were able to share which sign was which. We observed the person at a meal time and staff responded appropriately to the person's signs and were able to support them.

Staff we spoke with had a good understanding of how people communicated. One staff member told us "[Name of person] communicates by "reaching out to you, grabbing you. If you give him a choice he will choose." The staff member told us the person had a communication board to help them show staff what they wanted The staff member told us "You get to know how they are, when they're not happy, what they want."

We checked if the service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We found the registered manager had implemented a number of pictorial information boards and had identified the need for additional communication training for staff.

One person had a DVD showing how to communicate with them using 'intensive interaction'. Intensive interaction is a way of communicating with a person by taking the lead from them and mimicking their actions or sounds. On day two of our inspection a member of staff was watching the DVD to gain a better understanding of how to communicate with the person. The registered manager advised us they had arranged for staff to receive Makaton training. Makaton is a specific way of using signs to communicate with people.

People were treated with dignity and respect. We observed staff to knock on bedroom doors before they entered. Staff were able to tell us how they supported people to maintain their independence. One staff member told us "Always try and encourage clients to do what they can for themselves this will help keep their independence for as long as possible, lots of prompting and lots of encouragement." They went onto to say "By giving our clients the choice keeps independence, and gives our clients a bit of control over their own lives which they have a right to do." Another staff member told us "Always follow care plan. Promoting independence is important I am able to do so by giving clients choice and helping them make their own decisions."

People who required additional support had access to advocacy services. Advocacy gives a person independent support to express their views and represent their interests.

People's information was stored securely to protect their privacy. We found staff ensured doors to offices were shut and locked to avoid a breach of data protection.

We received positive comments from relatives about the access people had to activities, both inside the home and the local area. One relative told us their family member had been taken to the beach one weekend. They went on to tell us about how the staff supported their relative to go to the shops to buy his favourite magazine. Staff we spoke with told us there was more going on. One staff member told us they had supported people to make a personalised door marker. This was hung on the bedroom door while they stayed at the home. The staff member told us why each piece of art was personalised. For instance one person had a picture of a guitar as they liked music. Another staff member told us "Clients are making their own choices. Client preferences for activities are in their care plans; this allows staff to plan ahead and to ensure that there will be enough staff to clients. It empowers clients and keeps them motivated and happy to come back to respite to make it an enjoyable time, tailored to their needs. The client's happiness is shown through their body language, facial expressions and emotions, for clients who are able to communicate will communicate to us and let us know whether they are happy or not." We were informed about other activities which included a boat trip, a visit to the cinema and a picnic in a local park. One relative told us their family member had been out with staff and had met with a family friend. The staff had sent the relative a picture of them out. They told us it was clear the person looked happy.

Requires Improvement

# Is the service responsive?

## Our findings

At the previous inspection we found people did not routinely receive a personalised service. We found care plans did not provide enough detail for staff to follow. For instance one care plan referred to the person as 'X'. We asked the provider to improve. They sent us an action plan detailing how they would improve. At this inspection we found some improvements had been made.

One significant improvement introduced was the pre-admission process. Since the last inspection the home had introduced a robust system prior to a person being admitted. A weekly meeting was held between the management team and support staff. Each person who was due into the home was discussed. The meeting looked at all areas of the person's care. For instance, how many staff were required to provide safe care and if any changes had occurred in the person's care needs. In addition to the meeting a person or their representative (usually a family member) was asked to complete a pre-stay checklist. We received feedback from three relatives that they felt this had been a useful addition to making their family member's stay at the home safer. One relative told us "There seems to be new processes in place which are stricter. The pre-stay check form is really good such as anything new that's come up since the last stay or anything that they need to be aware of."

The staff had been undertaking person centred review training. Staff we spoke with were complimentary about the training. One staff member told us "Training has helped me grow in confidence and support me… I feel I have benefited from the training."

The registered manager had a system in place to review each person who stayed at the home. A monthly meeting had been arranged with staff from the home, and external professionals including health and social care staff. The meeting had planned to discuss at least three people who stayed at the home. We noted as a result of meetings held to date some people had been referred to external professionals for a review of their care needs. Actions were drawn up following the meeting.

The provider had identified the need for an additional role within the home. A family liaison officer post had been created and interviews were due to take place. The role was created to provide a co-ordinated approach to the booking of respite care. Relatives we spoke with were complimentary about the role. There was a member of staff who had been covering a similar role. One relative told us "The lady who does the bookings is excellent."

We found ongoing improvements were required in the content of the care plans. Not all the care plans we looked at provided sufficient and accurate information about the care a person needed. However a support plan summary had been created which provided good information.

One person had complex needs including learning disability and epilepsy. The person had an ileostomy and a gastrostomy tube (also known as a PEG). An ileostomy is where the small bowel is diverted through an opening in the tummy. The opening is known as a stoma. A special bag is placed over the stoma to collect waste products that usually pass through the colon. A gastrostomy tube is a way of passing food, medicines

and fluid into the body via a tube which is passed through the skin into the stomach. All of the person's medicines were given via their gastrostomy tube. The person's 'eating and drinking' care plan stated, in red print, "If ileostomy becomes blocked, try to flush water through first, if still blocked, must ring emergency service, as (the person) may require hospital treatment". An ileostomy would not be flushed as described in the care plan. This care plan should have referred to the person's gastrostomy. We brought this to the attention of the registered manager who spoke with a team leader. The registered manager told us "It's wrong."

The same person's 'support plan summary' under 'eating and drinking SALT recommendations' referred to the person eating independently with a spoon and drinking from a plastic beaker. However, it made no reference to the person's nutritional intake via PEG. Also, the plan mentioned a 'colostomy bag' when the person had an ileostomy. There was no reference to PEG feeding in the eating and drinking care plan. There was no risk assessment to specifically address the risks associated with the person's gastrostomy such as the tube becoming blocked or displaced or infection occurring at the (PEG) stoma site. We discussed this with a team leader, including the importance of seeking professional assistance to firstly identify possible risks. The team leader informed us they would seek advice from a specialist nutrition nurse.

One person had an epilepsy risk assessment which stated a 'Team leader to brief staff on who is responsible for emergency meds on shift'. However under the section 'recommended control measures and action plan' it stated the person 'does not have any emergency seizure medication'. This was potentially confusing.

Another person's care plan for medicines referred to taking a medicine for controlling blood sugars four times daily whereas their medicines risk assessment stated that this was taken three times a day. The person's diabetes risk assessment referred to 'blood glucose level dropping .This is called hypoglycaemia or HYPO'. It mentioned possible symptoms. However the risk assessment did not include hyperglycaemia (raised blood sugar levels).

Another person was newly diagnosed with diabetes. We found a note on their care plan that the keyworker (a staff member who was responsible for co-ordinating the person's care) was updating the care plan. It stated the care plan would be reviewed when the person was next to stay at the home. We found the person had stayed at the home twice since the note was written. One of the stays had been for over two weeks. However no diabetes care plan or risk assessment was in place. We noted the person's blood sugars had reached 21.9 on one occasion. Staff we spoke with did not know what to do in the event of high blood sugar readings.

These were all continued breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the provider's 'Complaints and Compliments file'. We saw that five compliments had been received since September 2017. One of these read "After an unsettling time at Seeleys, I'm pleased to say how much the service has improved." Complaints and concerns had been received during the same period. We saw that these had been dealt with in a timely manner with apologies made as appropriate. However, we noted that a complaint received on 19 October 2017 via a member of the community learning disability team had not been logged accurately. There was no indication that action had been taken in response to the complaint. We discussed this with the operations manager.

The provider sought feedback from people who stayed at the home and their relatives. We saw that the service had conducted a 'Family and Carers Survey 2018'. We reviewed six completed responses. These were mainly positive. Respondents thought that the service was safe, the staff caring and the manager

approachable. The registered manager had introduced a number of different communication routes to seek feedback from relatives. A monthly newsletter was sent to people and their relatives. A programme of coffee mornings had been arranged for relatives to drop into the home to meet with staff.

The home did not support anyone at the end of their life. People with complex medical needs were not referred to the home for support. Where people required community health needs, for instance, leg dressing, this was provided by a local healthcare practice.

Requires Improvement

# Is the service well-led?

## Our findings

At the previous inspection carried out on 27 and 28 June 2017 we found people who received care and treatment were not routinely offered an apology when things went wrong. There is a legal requirement for providers to be open and transparent. We call this duty of candour (DOC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We found this was not happening previously. We asked the provider to ensure improvements were made. At this inspection we checked if improvements had been made. We found the registered manager and provider were fully aware of incidents that met the DOC thresholds. We have been satisfied the provider is no longer in breach of this regulation.

At the previous inspection carried out on 27 and 28 June 2017, we found the provider did not always inform CQC of certain events it was legally required to. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We asked the provider to ensure improvements were made. At this inspection we checked if we had been notified of events when required. We checked our records against the provider's records. We found improvements had been made and we had been notified when required. We have been satisfied the provider is no longer in breach of this regulation.

At the previous inspection carried out on 27 and 28 June 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found multiple areas of record keeping which presented a risk to people. Risk assessments lacked specific detail to ensure staff could care for people safety. Systems were not in place to manage and record accidents and incidents. There was a lack of accountability and good governance. We issued a warning notice to the provider. The date the provider needed to become compliant with the regulation was the 2 October 2017. At this inspection we checked if the required improvements had been made.

We found on-going concerns about records management. However we acknowledged some improvements had been made. We looked at 12 care plans for people who had either received respite care or who were staying at the home at the time of our inspection. We found gaps in the records. For instance one person with a diagnosis of diabetes had no risk assessment in place to advise staff on how the condition should be managed. Another person with the same condition only had advice for staff on low blood sugars and what action should be taken. The file contained no information for staff to follow in the event of high blood sugars.

In another person's file we found incorrect and potentially confusing information about how to manage deterioration in their condition.

One person had been visited by a GP and had been prescribed antibiotics. We asked the registered manager if we could see the records relating to the events which led to the GP visit. We found information was difficult to follow. It was not easy to following the course of events as information was in three different places. We spoke with the registered manager about this and they agreed it was not clear.

Staff used a communication book to record information to share with their colleagues. We spoke with staff about discussion they had with relatives about a person's respite care booking. We found some staff used an individual's diary, others used the communication book and some staff used a communication summary. We spoke with one member of staff who told us they had spoken to a parent about a review meeting. When we asked to see the notes written about the telephone call, the member of staff told us "I didn't record it."

We found mixed practise around the management of reporting repairs. Staff were required to report repairs via an online portal, however they did not have access to any update on the repair. We spoke with one of the staff who took a lead in health and safety. They showed us a health and safety tracking form which had been created. However this did not routinely record what had been reported and when the action had been carried out.

These were all continued breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the provider had successfully recruited a manager who has since registered with CQC. We received positive feedback from people, their relatives and staff about the new management structure. In addition to the registered manager position the provider had created a team leader post. This provided an additional level of management and accountability to the service.

One relative told us the service had "definitely improved." Another relative told us "I will say they have done a great job in bringing up the place." Other comments from relatives included "[Name of registered manager] manages it well," "Certainly well led now. The lady who's now taken over is doing a good job. She's trying to involve us in all sorts of initiatives" and "We feel we could go and see them there and they would be quite welcoming. If they felt we needed to discuss anything. We would feel able to." We received many more positive comments about how the service was managed and how welcome relatives felt.

We found the registered manager displayed a commitment to improving the service. It was clear they had been able to change the culture of the staff. We found all the staff we spoke with were dedicated to making improvements. The registered manager communicated well with staff and provided support and guidance as well as helping the new team leader to develop their skills. Comments from staff included. "Very well supported, excellent manager," "[Name of registered manager] is a great role model and is full of encouragement to all the staff, she has given us full support, "[Name of registered manager] involves us in all changes and updates" and "Our manager is professional, supportive and has high expectations of her staff team, strives to provide a well-led service from every angle." Another member of staff told us "She [registered manager] is an excellent role model, she has inspired me. In staff meetings we are asked if the changes would be beneficial to people."

Staff were able to communicate the values of the organisation and we found they were committed to continuous improvement. Staff told us they felt valued and felt their views would be listened to. We found staff were relaxed in the company of senior management. A staff conference had been held to share the organisation's values. We received positive feedback from the staff about the event.

The provider had a programme of robust systems in place to monitor their performance and drive improvements. Since the last inspection we had received regular updates from the provider and registered manager about the changes they had planned. The provider had developed a new quality assurance framework. We noted this has been updated since it was first introduced, which demonstrated a continuous desire to improve the service provided. The operational manager carried out a monthly audit, which looked at key areas of work in the home, including health and safety, infection control and accidents as examples.

The provider and registered manager arranged a number of key meetings with staff and external healthcare professionals. Staff told us they had regular team meetings in which changes were communicated. One staff member told us "We have regular staff meetings and team leader meetings every week and minutes are taken."

We were provided with evidence of meetings held with different departments of the provider. For instance a regular meeting had been set up with the property team and the health and safety team. We found there was a noticeable shift in accountability since our last inspection. We found the provider was keen to listen to feedback and improve the service provided. This was supported by a clear definition of roles and responsibilities within the organisation.

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<br><br>The service did not routinely assess risks to people and provide staff with enough information on how to support people safely. |

**The enforcement action we took:**

We imposed a condition on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>We found On-going omissions in record management. We had previously issued a warning notice and at this inspection we found it had not been complied with. |

**The enforcement action we took:**

We imposed a condition on the providers registration.