Buckinghamshire County Council

Seeleys House Short Breaks Centre

Inspection report

Seeleys House
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20 May 2019

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Seeleys House Short Breaks Centre is a residential care home offering a respite care service for people with a learning disability and or physical disability. People typically stay at the home between one and 14 nights. The service is registered to provide support to a maximum of 12 people. However, the service has decommissioned some rooms and had eight rooms available per night.

People's experience of using this service:
We observed some positive and engaging interactions between people and staff. Relatives were complimentary about the improvements within the service. One relative told us "It is the best it has ever been". Other comments included "My son has complex needs and is looked after very well", "We are very pleased with the care he receives" and "We've always been pleased, absolutely" and "I know she is treated with kindness."

People were not routinely protected from avoidable harm. One person, who was at high risk of choking, had been left unsupervised in the dining area. Risk assessments were not written or routinely available to staff to advise them on how they should support people safely.

The provider did not robustly ensure people's human rights were upheld. The service did not always carry out mental capacity assessments or best interest assessment for restrictive practice.

The provider had put measures in place to monitor and improve the quality of the service. This included weekly improvement meeting with bi-weekly attendance by a director of the provider. Prior to each person being admitted to the service a pre-admission checklist was completed. This was to identify if there had been any changes to the person's level of need. We found the processes in place did not always ensure people's records were updated in a timely manner.

Improvements had been made to the environment and people's experience of the service.

People were supported by staff who had been recruited safely and were provided with opportunities to keep their skills up to date.

People were protected from abuse as staff had received training and were confident to raise concerns to the local authority.

People were treated with dignity and respect. Staff were knowledgeable about people's likes and dislikes.

People were supported to engage in meaningful activities. People went on visits to the local area, shops and cinema.

The provider facilitated coffee mornings for relatives to meet up and engage with peers. Systems were in place to seek feedback from people.

Rating at last inspection:
The service was rated Requires Improvement at the last inspection on 19 February 2018 20 February 2018 21 February 2018 (Published 30 May 2018).

Why we inspected:
The inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement:
We found areas of practice where the provider was not meeting the regulations. These were in relation to the management of risk, quality assurance processes and ensuring people were supported in line with the Mental Capacity Act 2005. We found ongoing improvements were required to ensure the service had good governance.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up:
We will follow up with a further inspection of this location to check that the provider has achieved compliance in those areas in which this report highlights significant concerns. We have also asked the provider to submit an action plan which outlines what they will do to improve the service and by when.

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

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Seeleys House Short Breaks Centre

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 two inspectors. An expert by experience made telephone calls to a sample of people who used the service and their relatives on 16 May 2019. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care of people with a learning disability.

Service and service type:
Seeleys House Short Breaks Centre is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a registered manager. The service had a manager who had applied to become registered with the Care Quality Commission. The manager had been confirmed as registered with CQC the day after the first day of the inspection. We have referred to them as the registered manager in the report. Registered managers and providers are legally responsible for how services are run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity took place on 16 and 20 May 2019.

What we did:
We used information the provider sent us in the Provider Information Return (PIR). Providers are required to send us key information about their service, what they do well and improvements they plan to make. This information helps support our inspections. Throughout the inspection we gave the provider and registered manager opportunities to tell us what improvements they had planned.

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 contacted social care professionals, to seek their views about people's care.
We spoke with the registered manager, service manager and head of direct support.
We spoke with nine staff members in a range of roles.
We spoke with three people who use the service and five relatives. The EXE spoke with a further five relatives over the phone.
We checked some of the required records. These included five people's care plans in detail and a further three to look at the management of risks. We observed medicine administration and looked at records relating to medicines. We looked at five staff recruitment files and staff training and development files. Other records included those which related to safety of the premises, accident forms, auditing reports and complaints.
We observed the morning routine and breakfast time on one day.
We observed the staff handover session between the morning and afternoon shift on one day.
We send emails to staff and relatives following the site visits to seek further feedback from them.
Following the site visits we reviewed the information gathered and sought further information from the provider.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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.

Assessing risk, safety monitoring and management:

●At the last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the poor management of potential risks to people. We took enforcement action to help the provider to make necessary improvements to ensure people received safe care and treatment. We issued a notice of decision to impose conditions onto the providers registration. We imposed three conditions to the providers registration. At this inspection we found some improvements had been made. However, we found people were not routinely and robustly protected from the risk of harm.

●We found care files contained risk assessments for a range of situations. These included assisting people to move, accessing the community, self-harming behaviour and management of diabetes. These risk assessments were not always available to staff.

●However, appropriate measures were not always put in place where risk assessments identified potential hazards. One person had been assessed as being at high risk of choking. A health professional had assessed the person and provided guidance. The risk assessment in the care plan did not contain all of the recommendations from the health professional. On the day of our inspection we observed practice that put this person at risk of choking. We discussed our immediate concerns with the registered manager and provider. Following the first day of the inspection we were sent updated information about how the service was to manage the risk of choking.

●One person was assessed as needing to have bed rails when in bed. Staff were not able to provide us with a bed rails risk assessment for a period of half a day. The risk assessment provided to us contained inaccurate information on who should be contacted if the person had suffered an injury as a result of entrapment. We pointed this out to the provider who later arranged for the risk assessment to be updated.

●One person was deemed at risk of pressure damage due to their posture. This was reported in a mobility support plan, however, there was no guidance for staff on how to minimise the risk of pressure damage. We highlighted this to the registered manager and provider. Following the inspection site visit we received a risk assessment document which identified how staff should minimise the risk of pressure damage. The provider had also arranged for staff to receive re-fresher training on the topic and staff had access to information leaflets. The provider later provided evidence that a risk assessment had been written prior to the date of our inspection. However, this guidance was not readily available for staff.

This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Equipment was provided to help people reposition, such as hoists. Equipment was serviced to ensure it was in safe working order.

●The premises were maintained well. Gas, electricity and water supplies were checked to ensure they

conformed to acceptable safety standards.
●Fire safety checks were carried out at the service. These included checks of alarm call points, emergency lighting and practice drills. Personal emergency evacuation plans had been written for each person, to outline the support they would need to leave the premises in the event of a fire or other emergency. Staff and people who used the service responded promptly to an unplanned fire drill on one of the days of the inspection and evacuated the premises safely.
●Fire wardens were on duty on each shift to ensure people's safety.
●The service had recently been visited by Buckinghamshire Fire and Rescue Service (BFRS) to follow up on previous concerns around fire safety. We received positive feedback from BFRS from their visit. A fire officer told us "BCC have made significant improvements to their fire safety and fire safety management since taking back the services in 2017." However, they also advised, following their recent visit they had made two recommendations regarding fire doors and staff training. We have asked the provider to advise us on what action they will take as a result of the recommendations. They confirmed with us that "All staff have annual classroom based fire awareness, warden training."
●The service carried out twice daily environment checks, we observed noted repairs were reported in a timely manner.

Staffing and recruitment:
●People were not always supported by enough staff to meet their needs. We found more staff were required to support people, especially at meal times. This was supported by what we observed and what staff told us. On day two of the inspection the registered manager told us they had acknowledged this and had increased staffing levels.
●Staffing rotas were in place to ensure there was appropriate support for people. There were systems for providing support for staff out of hours. Each shift had a designated lead member of staff who co-ordinated the shift.
●Robust recruitment procedures were used to ensure staff were fit and suitable to work with people.
●Staff had access to an on-call manager outside of office hours. A senior manager was rostered onto each day.

Using medicines safely:
●People's medicines were managed and stored safely at the service. Each bedroom contained a locked medicines cabinet.
●There were procedures and training for staff on safe medicines practice. Staff were assessed before they were permitted to administer medicines.
●We observed staff followed safe practices when they administered medicines. This included washing their hands, wearing gloves, checking information on pharmacy labels and expiry dates.
●Records of medicines administered to people were in good order.
●Medicines which required additional controls because of their potential for abuse were stored and recorded according to good practice.
●The service had engaged with the clinical commissioning group (CCG) care home pharmacy team. The CCG had carried out a number of audits of medicine management practice. We noted where remedial action was identified the service took appropriate measures to improve practice.

Preventing and controlling infection:
●People were protected from the risk of infection.
●There were procedures and training for staff on infection prevention. Staff had access to and used disposable protective items, such as gloves and aprons.
●The premises were kept clean and hygienic. Laundry was managed well. Audits were carried out to check

staff followed good infection control practices.
●There were appropriate arrangements for the disposal of clinical waste disposed using an approved contactor. Waste bins were emptied regularly to prevent the build up of odours.
●The service had been awarded a rating of 5 (the highest rating) by the local authority, under the food hygiene rating scheme. This means hygiene standards are 'very good'.

Systems and processes to safeguard people from the risk of abuse:
●People were protected from abuse, staff had received training on how to recognise abuse and what to do in the event of a concern being raised.
●Staff had access to the local authority safeguarding policy and procedures.
●People had access to information about who they could talk to or contact if they were concerned about their safety.
●People's relatives told us they felt their family member was safe when they stayed at Seeleys House Short Breaks Centre. Comments included, "We've always been pleased, absolutely. They keep diaries. They take photos and keep us informed, there is good communication, and they are sensitive about [Name of person] needs and won't clash with dates if there is another child he doesn't get on with there." Another relative told us "Nice to know he is secure and safe. There is always someone familiar with him."
●The registered manager was aware of the need to report all safeguarding concerns to the local authority.
●One member of staff told us "If I suspected abuse I would record and report to my line manager. If I felt for any reason my concerns were not being taken seriously I would report to a higher management level.
●Another member of staff told us "I shall report the abuse to my shift leader if I didn't see any results I will report it to my line manager after that the manager above then safeguarding if nothing is being done."

Learning lessons when things go wrong:
●The registered manager and provider had systems in place to share learning when care was not delivered as planned.
●Since our last inspection the provider had facilitated weekly improvement meetings with senior staff from the provider and location. We have been able to identify the meetings focused on driving improvement within the service and learning from when things went wrong.
●The service received national safety alerts and the provider has systems in place to ensure any action required was undertaken in a timely manner.

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.

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.

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, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- At the inspection carried out on 27 and 28 June 2017 we found a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's human rights were not protected as staff did not fully understand the Mental Capacity Act 2005 (MCA). Staff did not always refer people who had restrictive measures in place to protect them from harm to the local authority (Supervisory Body) for an assessment of deprivation. We issued a warning notice giving the provider a date by which they needed to ensure staff complied with the MCA. At the inspection carried out on 19, 20 and 21 February 2018 we followed up on the warning notice. We found the service had made significant improvements and found they had met the warning notice. However, we found some people's ability to make certain decisions had not been assessed and recorded. At the last inspection we made a recommendation to the provider they ensured paper work completed complied with the code of practice for MCA. At this inspection we followed up on the recommendation.
- We found improvements had been made. Staff had a greater understanding of the MCA. However, we found mixed practice regarding the application of the MCA.
- Some people's care records clearly recorded mental capacity assessments for restrictions placed upon people. For instance, for the use of bed rails. Where the assessment concluded the person lacked capacity to agree to their use, a best interest process had been followed and recorded. However, this was not the case for everyone.
- One person was at risk of falling from bed and their wheelchair. Bed rails and a lap belt for their wheelchair were used when at the respite service. No mental capacity assessment had been completed for the restrictive practice. We noted the service had previously identified this was required in October 2018. In monthly audits it was highlighted a MCA was needed. However, when we inspected in May 2019 no records were in place.
- One person who was at high risk of choking, was observed to be eating a food item which a healthcare

professional had advised they should avoid eating. We highlighted this to the registered manager, manager and provider. The manager told us "It is her choice to eat that, if we don't give her toast she will not eat." We asked the manager if the person had capacity to weigh up the consequences of eating a 'high risk' food item, they told us "No." The manager went on to say the person's relative had requested they be given the 'high risk' food item. We asked if a mental capacity assessment and best interest decision had been made regarding this. We were informed by the manager that this had been completed. We did not find any documentation in relation to this. We asked the registered manager and manager to retrieve this. They were unable to do so. We could not be confident this person had been protected from avoidable harm and providing a 'high risk' item was in the person's best interest. Following the inspection we were given a copy of a mental capacity assessment and best interest decision for the 'high risk' food and confirmation on how the provider was going to manage the risks posed.

●Where the service had completed a mental capacity assessment, it was not always clear what the conclusion of the assessment was, this was due to incomplete forms. We discussed this with the registered manager and manager. They informed us when the form was completed online it did not allow the author to tick a decision. We also found mental capacity assessments not dated or signed by the author. The registered manager has assured us they will seek IT advice on completing the form online and ensure all forms completed are signed, dated by the author.

●We found the service had a lack of understanding regarding consent. The registered manager told us and we saw a letter dated in May 2019, the service had written to relatives to seek confirmation they consented on behalf of their family member to certain actions. For instance, to take photographs, or receiving support from the service. However, only individuals can give consent. Any decisions made for people who lack capacity need to be made under a best interest process. The registered manager was keen to show us one person's file, the service had received a completed consent form from a mother of a the person who attended the service. The mother had signed consent forms on behalf of her relative. No best interest process had been followed and the mother did not hold any legal power to act on the person's behalf. The provider acknowledged that "Mental Capacity Act and Deprivation of Liberty Safeguards are an area of on-going development in relation to the knowledge and skill of all staff at the service" and "We are continuing to develop and embed the knowledge and skills of staff regarding Mental Capacity Act and this remains a high priority, to ensure that people are involved in their decisions and that clients have as much choice and control as possible." We acknowledge the provider's recognition that more work is required. However, the service should have made more significant improvements in this area since our last inspection.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People were supported to eat and drink. Their dietary needs were identified in their care plans.

●People received the support they needed to manage meals. This included maintaining correct posture and provision of equipment to help them manage independently. People could sit where they wished in the dining room. At breakfast, we saw people were provided with their choice of food and drink. Encouragement was given by staff where people needed it, to help them finish their meal.

●Food and fluid charts were put in place where needed. We noted these were not always accurately maintained. When we observed the staff handover, we noted a reminder was given to complete these charts accurately. One person's record showed they had regularly gone 12 hours without a drink being recorded. We discussed this with the manager. Who told us " Staff have forgotten to write it on the chart," however, we could not find any reference to the person being given a drink in the 12 hour period. The manager was also unable to find any evidence and therefore we were not re-assured the person received adequate fluid whilst staying in the service.

●We recommend the service seeks support from a reputable source on ensuring people received adequate fluid and keep hydrated.
●Catering staff and care workers were aware of people's dietary needs and how they liked to have their food.
●People's nutritional needs which followed a religious, cultural or lifestyle choice were well-known by staff. For instance, people who observed and identified themselves as a Muslim were provided with Halal food. This was also clearly evident in their care plan.
●People had access to pictorial menus to support them to make a choice of meal.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
●An assessment of care needs was completed before a service was offered to people. This included assessment of physical and mental health needs and took into account any needs related to disabilities, communication and cultural needs.
Since the last inspection the service had introduced a system to review each person's care plan prior to admission to the service. A family liaison post had been created. The member of staff in the post contacted people and their family member prior to admission to check if there had been any changes in the person's need. We received positive feedback from relatives about the pre-admission process. Comments included, "[Name of staff] is amazing," "I find the booking system very well managed" and "[Name of staff] is great, she knows what we need, we had a recent issue with a change in medication, I needed to get a new form completed by GP." Another relative told us "On one occasion the medication was outdated. They got straight back, phoned back, and we got some sent out to them. I thought that was fantastic that they had done this and I didn't realise it was out of date! We changed it all over and everything was fine."
●Care plans recorded people's needs, choices and preferences for how they wished to be supported. This included their likes, dislikes and preferred routines. Staff were familiar with these.

Staff support: induction, training, skills and experience:
●People were supported by care workers who had the skills and knowledge to meet their care needs.
●New staff completed an induction before they worked unsupervised. There was a brief induction for temporary workers, such as agency staff.
●Staff received training the provider deemed mandatory. Where additional training needs were identified the provider arranged bespoke training. For instance, one person was fitted with a magnetic device to help control their medical condition. We observed staff who supported them had attended training on how to use it.
●Senior staff were supported to study towards management skills. Staff received a monthly newsletter in which they were informed of upcoming training courses. The newsletter was sent electronically and a link to an application for the training course was available.
●Agency staff who worked at the service on a regular basis were enrolled onto the provider's training courses to ensure they were equipped with the right skills to work with people.
●Staff were supported through supervision and had an annual review of their performance. The registered manager had systems in place to monitor when staff had received one to one meetings and had attended training.
●Regular staff meetings took place to discuss people's needs and to look at ways of developing the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
●Three handover meetings occurred each day. This was to ensure important information was shared with staff. Information from the family liaison officer was shared with team leaders. We noted this was written in a contact sheet and a communication book.

●Each handover identified staff to carry out certain tasks. This was written on a shift handover sheet which all staff needed to sign. The registered manager told us, "We have worked really hard on the form to ensure all tasks are assigned and staff are accountable."
●Staff worked well together and with external agencies, such as GPs and district nursing services.
●Information about people's needs was shared with staff in a range of ways. These included handover meetings and a message book.
●People's care plans identified any support they required to meet their healthcare needs.
●Records showed the service has referred and liaised with other agencies about people's care. For example, district nursing support had been requested ahead of someone's stay.

Adapting service, design, decoration to meet people's needs:
●The building was designed for its purpose and had been fitted with adaptations and equipment to meet people's needs.
●We noted significant improvements had been made to the environment. We observed where staff identified deficiencies in furniture these were reported and acted upon in a timely manner.
●Each person had their own bedroom, close to toilet and bathroom facilities. People could use the lounge and dining areas to sit in. There were garden areas with seating which people could make use of. On the first day of the inspection a coffee morning was being held, we observed many family members sitting in the garden.
●A sensory room was in the process of being created whilst we were at the service, to provide a quiet area for relaxation.
●The provider advised us in the provider information return they had planned to involve people in decisions around the environment.

Good

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.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
●People were treated with respect. We heard staff spoke politely with people and engaged with them well. For example, staff asked someone "Are you ready, [Name of person]?" before they gave them their medicines. Another member of staff was speaking with someone who liked a particular pop singer. In conversation about a song, they said "I don't know that song. Will you teach it to me after breakfast?" Another member of staff could see someone was finding it difficult to open a packet and asked them "Would you like me to open that for you, [Name of person]?"
●The service supported people from a range of cultural backgrounds. We saw information was displayed about Ramadan and the practices that were followed during the holy month.
We received positive feedback from relatives about their experience of the service. One relative told us " It is the best it has ever been." Other comments included "I find the care given at Seeleys is very good," "The staff are always laughing and joking" and "The staff are interested in him. He has got a great sense of humour; you can have a laugh with him, which they have picked up on. They are happy to see him."
●People's relatives told us their family member enjoyed staying at the service. Comments included "Within 20 minutes of him being home and he turns to us and says when can I go again?," "[Name of person] really enjoy his time at Seeleys. He was asking me when he was going next" and "She wouldn't want to go there if she didn't like the staff." This was supported by our observations. One person who had stayed the night before the second day of our inspection kept asking staff "When next, when I am coming next" they had a big smile on their face as they were asking staff.
●People's relatives told us their family member was supported by staff who knew them and how to look after them. A relative told us "When he returns from respite he looks clean and well presented. The staff are super friendly and you can tell them your concerns. I am thrilled with them." Other comments included "love and kindness is showed to her on every stay" and "The loving care and joy within can never be replaced."

Supporting people to express their views and be involved in making decisions about their care:
●Each person had a keyworker, which was a named member of staff who supported the person to coordinate their care. Keyworkers were responsible for making changes to each person's care plan to ensure it was reflective of their needs.
●On the first day of inspection we noted a relative attending the service to review their family members care plan. We later spoke with them and they told us "I have provided information to the staff about [Name of person] eating, I have taken pictures to show how much he would eat." Other relatives told us they were involved in care planning for their family member. Comments included "We had a meeting and they did ask about everything what she likes and this and that and what she is like" and "We always have good communication."
●The provider told us in the provider information return (PIR) that " further development of client, family

and carer engagement is a priority for 2019."

Respecting and promoting people's privacy, dignity and independence:
●People were treated with dignity and respect. Relatives told us they were happy with how their family member was supported. One relative told us "They wash her, clean her teeth. She always looks neat and tidy."
●People were supported by staff of their choice and met with their cultural needs. One relative told us "When he takes a shower, he has a male attendant, which is good."
●Care plans and other records reflected a dignified approach to working with people. For example, one person's care plan instructed staff to "Always keep them informed of where you are guiding them" and "Ensure you walk with [Name of person] at their own pace."
●Staff worked well with relatives in an integrated way. For example, care records identified if family members were responsible for arranging prescriptions.
●People were supported to look well groomed and take pride in their appearance. We saw staff gently wiped any food spillages away from people's mouths after they had finished eating.
●A 'dignity tree' had been added to the entrance area. People who used the service, families and other visitors could write comments about their experiences on a leaf which was added to the tree. A dignity champion role had recently been created, to promote good practice at the service.

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
●Care plans were in place for each person. These identified people's needs in relation to a range of areas including protected characteristics under the Equality Act (2010), such as age, disability, ethnicity and gender. Local good practice was incorporated where relevant. For example, a care plan to support a person with diabetes had been well written.
●Care plans were reviewed prior to admission to the service. A pre-admission checklist was completed. Where changes had been identified this information was passed onto the team leaders to action. However, we found some care plans which had been identified as needing to be updated had not been actioned.
●We recommend the service seeks support from a reputable source to ensure people's current needs are reflected in care plans.
●The Accessible Information Standard (AIS) 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. The service had assessed people's communication needs as part of their initial and on-going care needs assessments. This included any aids people needed to communicate effectively. For example, whether people wore glasses or required hearing aids.
●We saw examples of how some information was provided in accessible ways. For example, food menus were available in a pictorial form.
●Staff told us how they worked with people to ensure effective communication. One member of staff told us " There is a board in the lounge which reflects the communication needs of clients that are due in for that day. We support people according to their preferred methods." Another member of staff told us "Using Makaton (sign language) or pictures of reference positive attitudes changes of faces"
●People were supported by staff who were knowledgeable about their likes and dislikes. A number of staff had worked in the service a long time and had developed good working relationships with staff. A relative told us "They [Staff] do seem to have a good relationship with him and always pleased to see him." Another relative told us "The staff know how to interact with him, they know him."
●People had access to activities of their choice. We overheard one person talking to staff about going to the cinema next time they were due to stay at the service. A relative told us "They know what he likes and let him loose with a hose as he enjoys waterplay; they make it happen, they have sussed him out."

Improving care quality in response to complaints or concerns:
●There were procedures for people to make complaints and compliments about the service. These were logged and records were kept of how they had been responded to. We could see apologies had been given, where necessary, and actions were taken to prevent recurrence.
●Records showed there had been eight complaints since the last inspection in February 2018. Twenty six compliments had been received during the same period.
●Peoples relatives told us they knew how and who to speak to if they had any concerns about their family

members care. Comments included "If I have any worries or [Name of person] has a problem I know I can pick up the phone and speak to someone" and "I know how to complain."

End of life care and support:

- The service did not provide support to anyone who had required palliative care or end of life needs.

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.

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 or may not have been met.

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

- Since the provider has been operating Seeleys House Short Breaks Centre, we have conducted three Inspections of the service. In all inspections we found breaches of the Regulations.
- At the inspection in June 2017 we found eight breaches of the Regulations. We issued two warning notices for Regulation 11 and 17 of the Health and Social Care Act 2008.
- At the last inspection in February 2018 we found an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the poor management of records. We found the service had not complied with the warning notice. We took further enforcement action to help the provider to make necessary improvements to ensure people received safe care and treatment. We issued a notice of decision to impose conditions the providers registration. We imposed three conditions on the providers registration. At this inspection we found some improvements had been made. However, we found quality audits did not always drive improvement in a timely manner.
- One condition placed on the provider's registration was "The Registered Provider must carry out monthly audits of Service User care plans, risk assessments and records of care delivery. The Registered Provider must on the first working day of each calendar month send the Care Quality Commission written evidence of the action taken or to be taken as a result of the audits carried out for the previous month." At this inspection we checked if the monthly audits were conducted and if they had driven improvement. In particular we wanted to ensure people's current needs were reflected in care plans and if people's human rights were protected.
- We found one person at high risk of choking was not supported to ensure they were safe when eating. Risk assessments were either not written or not readily available for staff to follow.
- Pre-admission audits were completed on a monthly basis. However, they did not drive timely improvement. For instance, in October 2018 the service identified a person needed mental capacity assessments (MCAs) completed for restrictive practices. The person had bed rails and a lap belt in place when at the service. We noted each monthly audit conducted from October 2018 to date stated the MCAs were needed. On day one of the inspection we found no MCA was in place. We highlighted this to the provider and they told us "We will however be robustly reviewing our improvement and service development approach in conjunction with our director of quality standards and performance at our weekly quality meetings that started 23rd May."
- We found an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service failed to routinely and robustly ensure people were protected from

avoidable harm.

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

●Since the last inspection the provider had made a number of changes to how they monitored the quality of the service provided. They told us in the provider information return (PIR) "We have embedded weekly service improvement meetings and have added a bi-weekly director led quality assurance meeting to ensure that we continue to improve the quality of the service."
●The provider and registered manager had carried out monthly audits and had developed a pre-admission programme. A meeting was planned each week to review the next weeks bookings.
●Information on any changes in people's needs was cascaded to team leaders to prompt them to update care plans. Relatives told us they found the pre-admission process useful and one relative told us "They even tell me when the medication is running out of date."
● Pre-admission processes highlighted gaps in records, however, action required was not routinely completed in a timely manner. However, we saw processes had been started by the service manager to monitor gaps in records. We also were provided with evidence a team leader had highlighted gaps in records to their colleagues. We acknowledge the improvements made to records which had been updated.
●There was a registered manager in post.
●Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We checked records held at the service against the data we had received from the service. We had been notified of events when required.
●Monitoring took place at the service. In-house audits included checks of medicines practice, infection control, catering, health and safety practice. External senior managers had also visited the service out of hours. We saw any actions which arose from these audits were followed up, such as updating staff training and ensuring information on display was accurate.
●Staff were vigilant in ensuring sensitive information was stored and handled in line with data security standards. Care plans were kept in lockable cabinets in an office which had keypad entry. Computers were password protected, to prevent unauthorised access.
●Staff had access to policies and procedures to keep up to date with good practice. Staff meetings included a 'policy of the week' to update staff.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
●There is a legal requirement for providers to be open and transparent. We call this the 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 checked if the service was meeting the requirements of this regulation. There had not been any events which met the DOC threshold, however the registered manager was aware of what actions were required.
●We acknowledge the provider had made significant improvements to the service since the last inspection. There was a commitment from the provider to maintain and sustain improvements. Senior managers attended meetings to drive improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
●A coffee morning had been introduced at the service, for relatives and carers to attend and meet each other and staff. The relatives we spoke with said they had enjoyed this informal gathering. A newsletter was

also sent to relatives.

●Relatives told us they had been kept informed of the proposed re-location of the service within the county and could be as involved as they wanted to be.

●Staff were supported through supervision and staff meetings.

●A monthly newsletter was sent to staff, this contained information about training and any national news affecting the care industry. For instance, one newsletter contained a link to a NICE report on peoples experiences of adult social care.

Continuous learning and improving care; Working in partnership with others:

●The registered manager attended the local registered managers network meetings and kept their knowledge up to date.

●The service worked with adult social care (ASC) colleagues within the local county council. One senior ASC worker told us "My experience of working with Seeleys short break service has been a progressively better experience over the last couple of years" and "I have found that the managers respond openly and promptly to concerns raised."

●The service worked in partnership with external healthcare professionals. Referrals were made to district nursing, occupational therapy and SALT when required.

●The service had been working with the clinical commissioning group (CCG) pharmacy team to drive improvement in the management of medicines.

●Each person had a 'A&E grab sheets' which detailed the support people would need if they had to go to hospital and important information about healthcare conditions.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured it complied with the Mental Capacity Act 2005.

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 The provider had not ensured risk to people were mitigated. People who were at risk of choking were not routinely supervised while eating.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems failed to drive improvement in a timely manner. Records relating to people's care and treatment were not routinely available to all staff.

The enforcement action we took:

We issued a Warning Notice.