Mr Kevin Gunputh

Seabourne House Care Home

Inspection report

1 Clifton Road
Bournemouth
Dorset
BH6 3NZ

Tel: 01202428132
Website: www.luxurycare.co.uk

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Outstanding** ☆
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

This comprehensive inspection took place on 26 and 27 October 2017. The first day was unannounced. At the last inspection in June 2015 we reported that the Regulations had been met and rated the service as Good.

Seabourne House Care Home is a care home without nursing for up to 48 people. It specialises in the care of people who are living with dementia. At the time of the inspection, there were 43 people using the service. It is located in a residential area of Bournemouth near the seafront. There are 45 bedrooms, which are situated on the ground, first and second floors; three of these rooms can accommodate two people. Most have ensuite toilet and shower facilities. The main lounge and dining areas are on the ground floor, but there are quieter lounges and a dining area on the second floor, and a seating area on the first floor. There is an enclosed garden to the rear of the property, with a small onsite parking area to the side.

Seabourne House Care Home is owned by the managing director of the Luxurycare Group, which owns three care homes in Poole, Dorset. Although not part of the group legally, it is treated as part of the group, overseen by the same senior management team and run in the same manner.

The service did not have a registered manager. However, the home manager had been in post since October 2016 and their application to register as manager was under assessment. This had been held up by some administrative issues and the registration was confirmed following the inspection. 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.

Staff and visitors spoke about the service having a family feel. There was a happy, friendly, welcoming atmosphere. Staff did not wear uniforms, which gave a sense of being homely rather than clinical. Staff and managers had got to know people well and to understand them. They greeted them with evident warmth and affection. Staff used information about people's lives to inform how they provided care and to organise activities that were enjoyable and relevant. This information helped staff and managers to understand why some people who used to work in an office liked to spend time with what they perceived as paperwork, and why someone who had been a nurse needed reassurance that everything had been done and that people were comfortable.

The service was exceptional at helping people express their views so they understood things from their points of view. The way staff worked was underpinned by a recognised model of dementia care that sees people's behaviours, including the way they communicate, as having meaning. In line with this model, staff were attentive to what and how people were communicating, even if people were not using words, and responded in a way that validated them. Staff spent time with people, making an effort to listen and understand them. For example, someone liked to sit in reception near the front door and the member of

staff on reception spent time in conversation with them, as did other passing staff, even though the person's words were not always clear.

The arrangements for social activities were innovative and met people's individual needs. Meaningful activity was key. People and relatives spoke highly of the activities they were involved in, both at Seabourne House and in the local area. Group activities regularly included minibus trips to local attractions, such as garden centres and local beauty spots. There were special events from time to time, such as the Luxurycare Olympics. More recently there had been a Caribbean-themed day involving food, music, decorations and a local drummer, who brought in instruments for people to play. Three activities staff organised and ran individual and group activities based on people's interests. They also kept track of what activities people had found particular benefit from.

The service played a strong part in the local community, where the manager was well known and was actively involved in building further links. People were encouraged and supported to engage with services and events outside of the service. For example, people and their relatives attended a dementia café held at a nearby care home. People often went to the local pub for drinks and meals. They had also gone to the nearby cliff top to watch the Bournemouth Air Show displays, and space had been made for residents to attend the turning on of the Southbourne Christmas lights in 2016. There were links with a theatre that held dementia-friendly film screenings and tea dances. Raffle prizes for special events were sourced from local businesses and local residents attended the service's events, such as the summer fete. A local resident had completed a volunteer DBS check and they and their dog visited the service each week.

The vision and values of the service were person-centred, with people at the heart of the service. These were owned by all and underpinned practice. This was evident in the way people, their visitors and staff spoke about the service and the manner in which staff interacted with people. All of the staff and managers we met were positive about their work. A member of staff remarked on the "the ethics that come through the company, values – they really care".

There was an emphasis on striving for improvement through reflective practice. The manager and director of care services reflected on accidents, incidents, complaints, safeguarding investigations, audits and inspections to consider how practice could be improved. This reflection and learning was recorded on 'opportunity for improvement' forms, introduced across the Luxurycare services to demonstrate and reinforce the provider's ethos of continuous learning and improvement. Learning from this service and the other Luxurycare services was shared between the services.

The service provided outstanding end of life care. Staff took steps to ensure people who were at the end of their life experienced a comfortable and dignified death, involving GPs and district nurses as necessary. They supported families and friends of people who were dying, with empathy and understanding. The chaplain employed by the provider had run a course for staff and families about the bereavement process and how families could be supported. Staff designated as end of life champions had devised a 'comfort box'. This contained items the person and their visitors might find comforting and helpful in the person's final days. The idea had come about after staff needed to source these items quickly earlier in the year when someone had been approaching the end of their life. A locked cupboard had been set up in a quiet room for visitors who were spending time with someone at the end of their life. They were given the key so they could access snacks and drink making facilities as they wished, without having to locate staff.

The service was flexible and responsive to people's individual needs and preferences, and people's rights were protected because managers and staff acted in accordance with the Mental Capacity Act 2005. People and their relatives praised highly the care they and their loved ones received. The manager and director of

care services kept up to date with best practice in dementia care and ensured this was adopted by the staff. The building and garden were adapted for people living with dementia, based on recognised good practice guidance.

People were protected from abuse and avoidable harm. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. People involved in accidents and incidents were supported to stay safe and robust action was taken to prevent further injury or harm. Medicines were managed and administered safely. Risks to people's personal safety had been assessed and plans were in place to manage these in the least restrictive way possible. There were also risk assessments and action plans in relation to the premises, which were maintained in good repair.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe because the service protected them from abuse and avoidable harm. Risks were managed in the least restrictive way possible.

There was a culture of learning from mistakes and an open approach. The service managed incidents, accidents and safeguarding concerns promptly and investigations were thorough.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

The service made sure people's needs were met consistently by staff who had the right competencies and knowledge. Staff were supported in their roles through training and supervision.

People were always asked for their consent to their care, where they had the capacity to give this. Staff had a good working knowledge of the key requirements of the Mental Capacity Act 2005.

People were supported with their health needs and appropriate referrals were made to health and social care services. People were protected from the risks of poor nutrition, dehydration and swallowing problems.

Is the service caring?

Outstanding

The service was very caring.

People and their relatives praised the caring attitude of the staff.

The service had a strong, visible person-centred culture. Staff were highly motivated to provide kind and compassionate care.

The service provided outstanding end of life care and people had the support they needed to have a comfortable and dignified death. Staff supported the families and friends of people who were dying with empathy and understanding.

Is the service responsive?

Outstanding ☆

The service was very responsive.

The service was flexible and responsive to people's individual needs and preferences. People and their relatives praised the care and support they received, which some said had exceeded their expectations.

There was an emphasis on meaningful activity. People took part in activities and events both at Seabourne House Care Home and in the local community. The manager and staff were actively involved in building community links.

Complaints and concerns were encouraged and seen by the provider and manager as part of driving improvement.

Is the service well-led?

Outstanding ☆

The service was very well led.

The service had a family feel. There was a positive culture where people and staff were encouraged to raise issues of concern, which were always acted upon.

The vision and values of the service were imaginative and person centred, with people firmly at the heart of the service. These were owned by managers and staff.

There was a strong emphasis on continual improvement. Systems were in place to promote a high quality service.

Seabourne House Care Home

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 comprehensive inspection took place on 26 and 27 October 2017. The first day was unannounced. At the last inspection in June 2015 we reported that the Regulations had been met and rated the service as Good.

The inspection team was comprised of an adult social care inspector and an expert by experience on the first day, with the same inspector returning alone on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses care services, in this case services for people who live with dementia.

Before the inspection we reviewed the information we held about the service, from notifications of significant events and from stakeholders such as the local authority. The provider had returned a Provider Information Return. This included information about incidents the registered manager had notified us of. In May 2017 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we met many of the people living at the service and spoke with six of them about their experiences there. Because most people were living with dementia that made it difficult for them to describe their experiences in detail, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk to us. We spoke with eight visitors. We also spoke with the manager, director of care services, provider and four care,

activities and supervisory staff. In addition, we spoke with a visiting health and social care professional.

As well as speaking with people and observing care and support, we viewed four people's care and support records, including assessments, care plans, records of care given and medicines administration records. We also looked at records relating to the management of the service. These included two staff files, staff rotas for the week of the inspection, quality assurance records, maintenance records and meeting minutes.

During and after the inspection, the manager and director of care services sent us additional information about the service. We also received feedback by email from three relatives and two health and social care professionals.

Good

Is the service safe?

Our findings

People and their relatives told us they or their family member felt safe living at the Seabourne House Care Home.

People were protected from abuse. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Information for people and their relatives about staying safe and reporting abuse was displayed prominently on noticeboards.

Risks to people's personal safety had been assessed and plans were in place to manage these risks in the least restrictive way possible. There were also risk assessments and action plans in relation to the premises, to help protect people from avoidable injury. There was a programme of regular maintenance and the provider held current certification in relation to the safety of electricity, gas, lifting equipment and fire precautions.

There were arrangements in place to keep people safe in an emergency. People involved in accidents and incidents were supported to stay safe and robust action was taken to prevent further injury or harm. Accidents, incidents and near misses were recorded and monitored to look for developing trends that might indicate where improvements were required. The home had a contingency plan for staff to follow in the event of various types of emergency such as utility failures or building damage.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. A relative told us, "The care home is very well staffed with people that do care about the residents' welfare and [person] is happy." Staff responded quickly to people's needs and did not rush their work.

Safe recruitment practices were followed before new staff were employed to work with people. These helped ensure that people were supported by staff with the appropriate experience and qualities. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Criminal records checks had been made with the Disclosure and Barring Service to make sure people were suitable to work in a care setting. A member of staff told us how some very caring new staff had been recruited. Separately, the manager told us she would only employ people who were sympathetic to the company's caring ethos.

Peoples' medicines were managed and administered safely. Medicines were stored securely. There was clear guidance for staff about the application of skin creams and medicines that were to be given on an as needed (PRN) basis. Medicines were audited regularly.

Good

Is the service effective?

Our findings

People and their relatives were positive about the staff, who they felt were skilled to meet their needs. They were also positive about people's quality of life at the service. Comments included, "[Person] has had fantastic service at Seabourne House. Previous to coming to Seabourne House [person] had not left the house in a couple of years but the staff there managed to persuade them to go out on a couple of occasions and [person] actually enjoyed themselves" and "We moved [person] and they are benefitting greatly. They are much more contented and happy within themselves."

New staff were supported through the induction process to develop the knowledge and skills they needed in their work. When staff first started employment, they undertook the provider's eight day induction programme. This was geared towards the Care Certificate, which new staff were expected to obtain. The Care Certificate is a nationally recognised qualification that represents a set of standards care workers adhere to in order to provide safe and compassionate care. This core training covered essential topics such as fire, moving and positioning people, first aid, infection control, health and safety, safeguarding adults and children, and the Mental Capacity Act 2005 and behaviours that challenge.

Staff had training following their induction to develop the skills and knowledge they needed. A member of staff said of the provider's training managers, "They're really wonderful people and tuned in to dementia". All staff had refresher training covering core topics such as safeguarding, fire safety and moving and positioning people. This took place annually or every two or three years depending on the topic. Those who administered medicines had annual training and competency assessments in medicines administration. Staff were expected to work towards qualifications relevant to their role, such as diplomas in health and social care for care staff.

In addition, as well as dementia awareness training at induction, care staff had a four day course on communication and caregiving in dementia. This is part of the model of dementia care adopted by the service. The model sees dementia as progressing in stages, helping staff understand how this affects the person and find appropriate strategies to help them live as full and enriched lives as possible.

The service was implementing a champions scheme. Care staff with particular interest and expertise had been designated as 'champions' for areas including equality and diversity, infection control, dementia, moving and assisting, and communication. Additional training was planned for the champions in their areas of interest, so they would be able to provide advice, guidance and supervision to their colleagues. Each champion had three practical tasks to complete for each quarter of the year, decided by them and agreed by the manager. For example, a target might be to deliver a certain number of observed practice sessions or competency assessments relating to the champion's area of expertise. There were incentives for champions to meet these targets.

Staff were supported informally and through structured supervision. Supervision took place in one-to-one meetings with line managers, in group meetings that discussed good practice and through observations of work, including competency assessments. Staff confirmed supervisions were carried out regularly and

enabled them to discuss any training needs or concerns they had. A member of staff commented, "The deputies and managers are all very nice people to work with. If you've got a problem they'll sort it out." They also said that they found their supervision "very useful".

There was an employee of the month scheme, where people who used the service, families and staff could vote for staff who they felt deserved the award. Information about the scheme was displayed on noticeboards around the service and the manager was actively seeking ways to improve participation.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

Where people were unable to give consent to aspects of their care, their rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. 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.

Where there were concerns about a person's ability to consent to aspects of their care, staff assessed whether the person had the mental capacity to give this consent. They recorded how they established whether the person had understood the decision. Where the person was found to lack capacity, staff made a best interests decision on the person's behalf, taking into account what was known of the person's preferences, values and beliefs in relation to this care. Staff consulted with the appropriate parties, such as relatives and doctors, in reaching these decisions. Matters covered by mental capacity assessments and best interests decisions included the delivery of care and the administration of medicines.

Some people did not understand they needed assistance with elements of their care and had occasionally needed staff to hold them safely in order to receive necessary personal care, in order to prevent them hitting out. This had last happened several months before. Safe holding was always subject to a best interests decision in line with the MCA. Safe holding was only to be used by staff trained in the specific techniques. Episodes of safe holding were recorded on a dedicated form and were reviewed and monitored by the management team.

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). The registered manager had recognised where people were being deprived of their liberty. They had made DoLS applications to the appropriate supervisory body. Supervisory bodies had set conditions on authorisations to deprive two people of their liberty. All of these conditions apart from one were being met. The manager was waiting to hear from the supervisory body regarding the condition that was not being met due to the person's declining health, which meant they were no longer well enough to take regular trips out. The service had a system to track expiry dates of authorisations and ensure fresh applications were made in time.

People and relatives were broadly positive about the food. One person described the food as "Not bad – some of the time it's very good but, you know, it's not gourmet". Meals were freshly cooked and looked and tasted appetising. Soft and pureed diets were presented as attractively as possible. People made menu choices the day before, but were able to change their mind on the day if they liked the look of the other option. The kitchen staff would also prepare an alternative if the people really wanted something else to eat.

Lunchtimes were relaxed and sociable occasions. Most people ate in the dining area downstairs, but others chose to eat in the lounge or in their rooms. There was also a smaller, quieter dining room available on the second floor. Dining tables were laid with tablecloths, serviettes, cutlery and wineglass-shaped glasses, to help encourage people to drink. People asked staff for condiments and looked very comfortable doing this. Pleasant music was playing in the background. Strongly coloured crockery was used, as research indicates this helps people who are living with dementia to focus on what they are eating. Staff were attentive and assisted people where needed, for example, helping them to sit closer to the table or to clean their hands. A member of staff who was assisting someone to eat talked about what the food was and asked if they could taste the strawberry.

People's dietary needs and preferences were documented and known by the care staff and kitchen staff. The home's chef kept a record of people's needs, likes and dislikes. Finger food was provided at mealtimes for people who found it easier to eat in this way. Where people had difficulty swallowing, which could put them at risk of choking, they had been referred to speech and language therapists for assessment and had safe swallow plans in place. Details of these were readily available for staff.

People were weighed regularly and their risk of malnutrition was kept under review using a recognised malnutrition screening tool. Prompt action was taken if people were identified as being at risk of malnutrition, for example due to unplanned weight loss. Staff followed the screening tool instructions, for example by fortifying the person's meals with butter and cream to increase the calorie content, more frequent weight checks and monitoring food and fluid intake. Where necessary, dietitian referrals were sought.

There were 'hydration stations' in communal areas. These had cold drinks and a variety of sweet and savoury snacks, such as fruit and crisps, for people to help themselves to. People used them throughout the inspection. Staff regularly provided drinks and snacks for people who did not get them for themselves. People had drinks to hand for much of the time.

Where there were concerns about someone drinking enough, staff kept a record of their fluid intake on the recently introduced electronic care records system. There was a target daily fluid intake for each person. However, some people's daily fluid intake totals looked low, although the people themselves did not look dehydrated and this suggested that the fluid intake records may not have been complete. The manager acknowledged that there was scope for improvement in fluid recording.

We recommend the service reviews its procedures for recording and reviewing fluid intake on the electronic record system, to ensure that entries are as far as possible complete and that action is taken if there is a shortfall.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A health professional who visited regularly spoke positively about the service, telling us staff supported people well with their health, contacted them when they needed to and followed the advice given. Other health professionals gave similarly positive feedback following the inspection.

The environment was adapted for people living with dementia. This was based on recognised good practice guidance such as that produced by the University of Stirling Dementia Service Development Centre. Furnishings, floor surfaces, corridor and hand rails, and toilet seats and lids, were provided in contrasting colours. Most bedrooms had ensuite shower rooms. Signage around the building was clear, with words and

symbols. People's bedrooms were easily identifiable with large printed names and photographs on the doors. There were memory boxes by the side, which displayed objects and photographs of significance to the person. These had recently been updated so they were more interesting and appealing. The first floor corridor had been painted with colourful wall friezes; the seating area at the end had been decorated in the style of a domestic lounge and looked much less institutional than it had previously. The lounge areas on the ground and second floors had also been decorated in a warm and homely style, with a quieter and more intimate area created at the end of the ground floor lounge. People had access to a fully enclosed garden, which had been overhauled over the spring and summer to provide sensory stimulation, with colourful and scented wild flowers and herbs, raised flower beds, a water feature, wind chimes, ornaments and a large suspended xylophone.

People moved around the home freely, if they were able to. The lift was unrestricted for people to travel between floors. Closed circuit television had been installed in communal areas. Where people were at particular risk, for example of falling, from moving around, infra-red movement sensors were used so staff were aware they were walking around and could provide assistance as necessary.

Outstanding ☆

Is the service caring?

Our findings

The service had a strong and visible person-centred and caring ethos. All of the people and visitors we spoke with complimented the caring attitude of the staff. Visitors confirmed they could visit whenever they liked and always felt welcome. Comments included: "[Staff] are great.... very caring and attentive", "I am very happy that [person] is here, the staff are always very helpful and pleasant, they are polite, and treat us like family, we are all on a 'first name' basis"; "Everyone is always really nice and treat [person] with respect... The management are also very attentive and supportive", "They're wonderful here, very caring, very lovely", "I love the friendliness and the eclectic mix of the staff. They and the residents are like one big happy family. Instead of dreading my visits to see [person] I look forward to them" and, "I am constantly amazed at how wonderful, patient, and caring the staff are with [person]… It doesn't matter what time I happen to call in, whenever there are staff with her they are brilliant, and I have nothing but admiration for them."

People who lived at the service and visitors were treated with kindness and compassion. Staff greeted them by name, with evident warmth and affection. Care was not rushed; staff worked at people's pace without rushing them, for example, when supporting them with their meal, assisting them to mobilise and when talking with them. For example, when staff assisted someone transfer into their wheelchair using a hoist, they explained clearly what they were doing and checking the person was comfortable with this before proceeding. The interactions were unhurried and the person looked comfortable.

Managers and staff were committed to working in a person-centred way. Managers strove continually to develop the approach of the staff team, motivating and inspiring them to continue offering kind, compassionate care. This was evident in the kind and caring approach of managers and staff throughout the inspection, and also in the way they spoke about people and their relatives. The expectation of a caring and person-centred approach to people was made clear to staff at induction, and was reinforced through ongoing supervision and training. The meaning of dignity and the effect of undignified care was explored through role play during staff training. Staff and managers told us how they expected their colleagues to be caring. Where there had been concerns about staff attitudes and behaviour falling short of this, the manager and senior management team had taken robust action, including disciplinary action where appropriate. The provider was part of the national Dignity in Care network, which aims to change the culture of health and social care services, improving the quality of care and the experience of people using services. This enabled them to learn about good practice elsewhere and draw on this for use at their services, as well as sharing their own good practice. Associated with this, there had been a 'Digni-Tea' afternoon tea event at the service the previous week to promote and celebrate dignity in care amongst residents, relatives and staff.

People's dignity was maintained. When people needed assistance with personal care, this was offered promptly and discreetly. Personal care took place behind closed doors. When people were assisted to transfer with a hoist between their wheelchair and chairs in the lounge, staff positioned a screen around them in case their clothes became dislodged. Some people needed protection over their clothes during meals. Large serviettes with printed designs (beads for women and a tie for men) were provided; these did not look obviously institutional.

People were valued and respected for who they were. During the inspection there was a tea party for all people and visitors who wished to attend, in honour of a person's birthday. They and their family had chosen a 70s theme and the activities team had organised fancy dress, decorations and music accordingly. Two visitors told us that staff and managers always made a big fuss over people's birthdays. The manager and activities organisers explained that every resident's birthday was celebrated in their preferred manner. There were photo displays of fun being had at recent birthday events.

Staff had got to know people well. The management team and staff understood people's backgrounds, which helped them form relationships with people and provide care and support in a way that suited them. This included developing individual and group activities that were enjoyable and meaningful for them, such as supporting someone to play the musical instrument they had enjoyed playing for a long time. It also helped managers and staff to understand some people who used to work in an office liked to spend time with what they perceived as paperwork, and why someone who had been a nurse needed reassurance that everything had been done and that people were comfortable. Care records contained detailed information about people's life histories and preferences, obtained from them and their relatives during the initial assessment and care planning process and added to thereafter.

The service was exceptional at helping people express their views so they understood things from their points of view. The way staff worked was underpinned by a recognised model of dementia care that sees people's behaviours, including the way they communicate, as having meaning. In line with this model, staff were attentive to what and how people were communicating, even if people were not using words, and responded in a way that validated them. People were often engaged in interactions with staff, even if they did not use speech. These interactions were meaningful and unhurried; staff took time to listen and understand people. For example, someone liked to sit in reception near the front door and the member of staff on reception spent time in conversation with them, as did other passing staff, even though their words were not always clear. Another person chatted sociably with the cook and a care worker shortly before lunch. When someone started dancing to some incidental music playing in the lounge, a member of staff joined them and the person clearly enjoyed the interaction. Staff used touch where people were comfortable with this, for example touching hands or putting an arm around their shoulders. People responded well, smiling and looking at the member of staff. Laughter and chatter often followed. Staff did not wear uniforms, which helped staff and people interact with each other as adults rather than as caregivers and patients.

Interpreters had been provided where necessary to assist people to communicate with staff and managers. Managers recounted how when a national of another country had been living at the service, staff from that country had been recruited specifically to assist the person to feel safe and settled.

The service promoted advocacy support to assist people in representing their interests. Around the home there were leaflets and posters to raise awareness of the support available from paid or voluntary advocates locally. The use of general advocacy was covered in staff induction, to give new staff an understanding of the advocacy support that people might need and how to access this. The role of Independent Mental Capacity Advocates was also covered during induction training. Staff had referred people to advocacy services where there were concerns that people's interests could conflict with those of other parties, such as relatives and commissioners of services where there were disputes about how the person's care should be funded. This had had positive outcomes for people and also for their relatives.

Relatives said staff kept them well informed about matters concerning their family members. Comments included, "The staff has always kept me informed on [person's] wellbeing", "I really appreciate phone calls and emails from staff to inform me of any problems" and, "The lovely young man who coordinates activities

sent me a few photos a couple of weeks ago where he and others had taken [person] out to the cliff top… she looked really happy." The manager and activities staff explained how they often emailed or texted photographs to families of their loved one taking part in activities. They said relatives had fed back how much they appreciated these. Relatives' meetings took place every eight weeks and were a social event, with food and drink. Following the last one for the year at the start of December, family members would be able to stay on for mulled wine and to decorate the Christmas tree with their loved ones. The service knew from feedback that these were the sort of things family carers missed doing.

People were able to spend their time where they wished, whether in their room or in communal areas. Whilst the main lounge and dining areas were on the ground floor, there some quieter communal areas on the first and second floors, for people to use as they preferred. People were encouraged to personalise their bedrooms with favourite possessions and pictures.

People and their relatives were asked about their preferences for end of life care. The service endeavoured to do this before this was needed, recognising that it might be a difficult topic to discuss when the person was approaching death. End of life care plans included psychological, religious and cultural needs.

Staff took steps to ensure people who were at the end of their life experienced a comfortable and dignified death. They involved GPs to ensure pain relief had been prescribed and was on hand if needed. The district nurses administered this if required.

Staff supported families and friends who were close to people who were dying, with empathy and understanding. The service had received compliments from relatives about how caring and supportive staff had been at such a difficult time. The chaplain employed by the provider had run a five week course for staff and families about the bereavement process and how families could be supported. Staff designated as end of life champions had devised a 'comfort box', which we saw in someone's room. This contained items the person and their visitors might find comforting and helpful in the person's final days, such as a soft blanket, a simple prayer book, a book of poetry, LED candles, hand lotion, lip balm, mouth swabs, a small CD player and some relaxing music. The idea had come about after staff needed to source these items quickly earlier in the year when someone had been approaching the end of their life. A locked cupboard had been set up in a quiet room for visitors who were spending time with someone at the end of their life. They were given the key so they could access snacks and drink making facilities as they wished, without having to locate staff.

A LED memorial candle was placed on a shelf at the reception desk when someone had died. This alerted staff to the death so they could speak with the management team for further information. A dove was placed on the door of a deceased person's room to alert staff that the funeral directors had not yet visited.

Someone who had recently died had a small, private funeral. The manager and staff were aware of what the person's preferences had been and had arranged a memorial service and party at Seabourne House to commemorate their life. The manager, who liked writing poetry, said they would write a poem to honour this person, as they had for others who had died.

Outstanding ☆

Is the service responsive?

Our findings

People and their relatives praised the care they and their loved ones received. Comments included: "Very good at keeping me clean and comfortable in bed", "I am very happy, [person] is well looked after... can't fault them", "[Person] is getting lovely care, very high standard", "I can give them a rave review. They've been fabulous with [person], absolutely fabulous", and "Really pleased with the way [person] is looked after." During our observations, staff anticipated people's needs and provided the care required. People were often positive in mood, smiling, laughing and moving to music. This reflected that their needs were being met.

People and relatives spoke highly of the activities they were involved in. Comments included: "They do something with them every day and they are brilliant with them..... they involve them, and take them out for teas and activities"; "The activities organisers are marvellous. They take him and help him to play snooker, and also play the guitar with him if they feel he is able".

Professionals who had contact with the service remarked on the way that care met people's individual needs and achieved exceptional results. A social care professional wrote in the visitors book during the inspection stating, "Exceptional home – love the atmosphere". Another professional commented, "I cannot remember any complaints from colleagues and have always been happy to recommend this establishment to potential residents and their relatives. They provide a superb and much needed service given our increasingly elderly and frail population."

The service strove to be known as outstanding and innovative in providing person-centred care based on best practice. It specialised in dementia care and almost all of the people there were living with dementia. The whole staff team had received training and worked within a recognised and respected model of dementia care. This meant people received consistent care from a staff team who understood how to communicate and meet the needs of people living with dementia. The manager and director of care services kept up to date with best practice in dementia care and ensured this was adopted by the staff. The service had joined up to best practice initiatives such as Dying Matters and the Alzheimer's Society's Dementia Friends programme.

People's needs were assessed before they moved in and once they were there, their care and support was planned proactively in partnership with them and their relatives. A large part of the preadmission assessment was finding out about people's life histories and social needs. The information was included on an "All About Me" form, which was shared with domestic, kitchen, care and activities staff before the person arrived. This helped them understand the person as an individual from the moment they arrived, which helped reduce any stresses associated with the move. Activities staff took this information with them when they went out on trips with people, as it contained the key information they needed to ensure the person's welfare, for example things the person might welcome talking about if they showed signs of becoming anxious, as a diversion.

Care plans were thorough, reflecting people's individual needs, strengths and personal histories and preferences. They covered all aspects of the person's life at Seabourne House, including mental and

physical health, communication, skin and pressure area care, nutrition, continence, personal care, night care, activity and social needs, family needs and advance care planning. These were reviewed regularly and kept up to date. People and their relatives were as involved as they wished to be in planning, delivering and reviewing care. For example, during the inspection a relative assisted their family member to eat a meal, as was usual for them. Another relative had had issues with their family member's missing laundry. They preferred to do this themselves and together with the service, they had worked out a system for recording what they took home with them. People's care records contained a 'care passport', which gave key information such as risks and health conditions and summarised the person's preferences and needs. Staff knew people well and had a good understanding of the care they needed.

The service was flexible and responsive to people's individual needs and preferences. Some men living at the service were reluctant to accept support with shaving when they were in their rooms. The manager had therefore set up a 'barber's box' in her office, with equipment for shaving such as a trimmer, towels and shaving foam. This way, these men got the support they needed from the manager in a manner that was acceptable to them.

Staff found creative ways to enable people to live as full a life as possible. The arrangements for social activities were innovative and met people's individual needs. All through the inspection we saw people engaged in things that meant something to them, whether during organised activities, ad hoc interactions with staff or simply watching or listening to something. For example, we saw people get up and dance to some background music, while others sat with their eyes closed and tapped their fingers. People were involved in day-to-day tasks as they chose, such as setting tables ready for lunch. There were items displayed at eye level around the corridors to provide tactile stimulation, such as colourful and glittery scarves, bags, dolls and soft toys and a 'washing line' of baby clothes. The dolls and soft toys were provided as some people who live with dementia like to hold what they see as babies.

Meaningful activity was seen as crucial. There were three activity coordinators who organised and ran individual and group leisure and social activities based on people's interests. One of the activities organisers explained how the activities staff had a system for keeping track of what one-to-one activities people found benefit from. The manager and activities organisers told us how they routinely played their guitars and ukuleles to groups in the lounge, or one-to-one with people who enjoyed this. Group activities regularly included minibus trips to local attractions, such as garden centres and local beauty spots. There were special events from time to time, such as the Luxurycare Olympics. More recently there had been a Caribbean-themed day involving food, music, decorations and a local drummer, who brought in instruments for people to play.

The activity coordinators compiled a monthly colour magazine for people who used the service and their visitors. This contained reports and photos of recent events, and league tables for the home's sports and skittles events.

The service had formed strong links with the local community, where the manager was well known and was actively involved in building further links. People were encouraged and supported to engage with services and events outside of the service. For example, people and their relatives attended a dementia café held at a nearby care home. People often went to the local pub for drinks and meals. They had also gone to the nearby cliff top to watch the Bournemouth Air Show displays, and space had been made for residents to attend the turning on of the Southbourne Christmas lights in 2016. Following suggestions from a person's family, activities organisers had linked up with a theatre that held dementia-friendly film screenings and tea dances. Raffle prizes for special events were sourced from local businesses and local residents attended the service's events. There had been a summer fete in August, which the manager said had been a quite a large

event with involvement from every resident, local people and businesses. In the run up to Christmas, children from local schools the service had links with had been invited in to sing Christmas carols, as had carol singers from a nearby club. A local resident had completed a volunteer DBS check and they and their dog visited the service each week. The manager had contacted the publishers of a monthly community magazine to ensure the service received a few copies each month, which were a means of finding out about nearby events.

People's spiritual needs were provided for, regardless of their faith or denomination. Some people went to local churches and were visited by representatives from churches. A Christian minister was employed as a chaplain. The chaplain provided pastoral, religious and spiritual care to people and their relatives, as well as pastoral support for staff and managers on occasion. They met individually with people (and their family members) who had expressed a faith during their pre-admission assessment or had requested a meeting. Following this they contacted with local representatives of the faith or denomination, inviting that community to visit the person and help continue their spiritual support. The chaplain led a weekly dementia-friendly Christian communion service during the inspection. The manager told us the chaplain did most of the funeral services for deceased residents.

The service's hairdresser had received the same in-depth dementia training as other members of staff. They had previously worked at the service. They told us some people used to choose not to have their hair done, but now felt more comfortable and asked for this, possibly because of the familiar face.

Complaints and concerns were taken seriously and seen as part of driving improvement. There was clearly displayed information about how to complain or raise concerns. Managers recognised people might have concerns they would not wish to deal with formally and encouraged people to raise these. Eleven complaints had been logged since the end of June 2016. There were two concerns logged in 2017 and three in 2016. These had all been acknowledged promptly, investigated thoroughly and responded to transparently. Where complainants were happy to have further contact about the matter, the manager had ensured they were satisfied with the response. Complaints and concerns were outnumbered by compliments, of which 19 had been logged in 2017. A relative commented, "I have never had cause to raise any kind of compliant or issue with the care home, but I know that if I did need to, I could easily do so. They are always very responsive to any questions, and always keep me informed."

Outstanding ☆

Is the service well-led?

Our findings

Seabourne House Care Home had a friendly, welcoming, family atmosphere. Visitors specifically remarked on this, talking about the family feel of the service. A visitor who had had regular contact with the service for some time said they felt the home had changed for the better since the arrival of the current manager.

The vision and values of the service were person-centred, with people at the heart of the service. These were owned by all and underpinned practice. This was evident in the way people, their visitors and staff spoke about the service and the manner in which staff interacted with people. All of the staff and managers we met were positive about their work. A member of staff who was not a manager told us, "I do truly love it, it's absolutely amazing. I come to work and have fun with people." This member of staff also remarked on the "the ethics that come through the company, values – they really care".

Prior to the arrival of the current manager a year before, the service had experienced a series of changes in manager. Staff morale had started to improve. A member of staff told us they perceived staff as more caring and compassionate now than they had been previously. They also said the manager created "a buzz" and was "sensational – I can't put into words how forward thinking she is".

The management team encouraged people, their relatives and staff to share feedback and raise issues of concern with them, which they always acted upon. People, visitors and staff had confidence the managers and provider would listen to their concerns, which would be received openly and dealt with appropriately. Relatives and staff told us they always felt able to approach members of the management team if they had any concerns. The manager said she operated an 'open door' policy and her office door indeed remained open when she was in the office, people who lived at Seabourne House often coming in and spending time with her.

The manager and provider valued feedback from people and their relatives, and acted on their suggestions. The garden renovation project had been prolonged because the manager had consulted with people, their families and staff about the features they thought it should have. Feedback was routinely obtained through quality assurance surveys of people and families, meetings for residents and for relatives, and care reviews. Quality assurance surveys were staggered, with every resident and family having the opportunity to return one in each 12 month period. Feedback from these surveys was analysed and fed back to the manager. Ad hoc feedback was sought through the manager's informal conversations with people and their families, a suggestion box scheme and a visitors' book. Residents' and relatives' meetings had recently been held separately to help both people who lived at the service and their families to feel they could speak more openly.

The director of care had devised a fee assessment tool in consultation with family members. This was aimed at inviting open discussion with families to negotiate a fee. The director of care told us the feedback they had had from families was that this helped them understand how the fee had been reached.

The manager was receptive to ideas for improvement suggested by staff. For example, one of the activities

staff thought using volunteers would help them improve the range of outside activities available to people. They had discussed this with the manager and had been tasked with finding suitable people, who would be DBS checked. Another member of staff told us there were regular staff meetings at which "you can talk and they'll sort it out". They also said they were "definitely" kept up to date with news about the service. There were regular team meetings and staff meetings; the dates for these had been announced at the start of the year, with two alternative meetings being organised for most, so that as many staff as possible could come.

As well as consulting with people, families and staff, there was an emphasis on striving for improvement through reflective practice. The manager and director of care services reflected on accidents, incidents, complaints, safeguarding investigations, audits and inspections to consider how practice could be improved. This reflection and learning was recorded on 'opportunity for improvement' forms, introduced across the Luxurycare services to demonstrate and reinforce the provider's ethos of continuous learning and improvement. An example of improvements that had been brought about was the development of a clearer system for monitoring expiry dates and conditions on Deprivation of Liberty Safeguards authorisations. This followed a monitoring visit to Seabourne House and had been shared across all the Luxurycare services. The manager had put in place a 'Going for Outstanding' action plan. This focussed on how the service could evidence good practice and develop further, in order to meet CQC's characteristics of Outstanding ratings.

A comprehensive programme of audits and checks was in place to monitor all aspects of the service, including care delivery and record keeping, medication, infection prevention and control, health and safety, premises and equipment, accidents and incidents and nutrition. These were undertaken by managers from the service, managers from other Luxurycare services and the director of care. Audits resulted in clear action plans to address shortfalls or areas of improvement, which the manager was quick to progress. For example, improvements had been made in procedures for administering medicines after an audit had found missing staff signatures. The issue was discussed at team meetings, staff administering medicines wore 'do not disturb' tabards and a separate experienced member of staff was on the floor while medicines were being administered. In addition, staff had received refresher training in administering medicines and the frequency of medicines audits was increased. In addition, the manager walked around the service several times a day to ensure the service was presentable and comfortable for people, as well as checking that the activities team were on track for the day and whether they needed any assistance. This ensured she was accessible and visible to people in the home.

Learning from this service and the other Luxurycare services was shared between the services. Managers from the services met regularly to share good practice and learning from incidents. There were also meetings from time to time for groups of staff from across the services to share ideas and good practice. For example, a meeting of activities staff was to be held in early November 2017 where a team from each home would be presenting the best work they had done over the past year to celebrate success and share learning.

The service had a clear management structure. The service manager headed up a team of deputy managers. Besides the service manager, there was a deputy manager on duty during the day. One of the service's management team was on call overnight in case there was a situation staff needed guidance with. Heads of care coordinated and worked alongside the care staff. Catering, maintenance and housekeeping staff were line-managed by the facilities manager who worked across all four Luxurycare homes.

The manager had been in post for over a year. Their application to register as manager had been held up by some administrative issues and was awaiting assessment. Their registration was confirmed following the inspection. The director of care services had for several years overseen the running of this service and its three sister Luxurycare services. The director of care worked closely with the provider, to whom they

reported. The managers of all four services met regularly to share good practice and any learning from incidents. The manager and director of care services told us there was regular communication between members of this team.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. The provider strove to improve the quality of care for people living with dementia, both in the Luxurycare services and in the wider community. The manager and director of care were involved in Partners in Care and Skills for Care learning hubs for managers. Within the past year, the director of care services had won the Venus Manager of the Year award for women in business in Dorset. The provider was chair of the Dorset Care Homes Association.

The manager had notified CQC about significant events. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

The rating from the last inspection was prominently displayed on the service's website and in the reception area.