Mr Kevin Gunputh

Seabourne House Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 23 and 26 June 2015. The first day was unannounced.

Seabourne House Care Home is a specialist dementia care home without nursing for up to 48 people. There were 35 people living there during our inspection, most of whom were living with dementia. Accommodation is situated on three floors of a converted and extended Victorian house. The three floors are connected by passenger lifts as well as stairs. There is an enclosed garden at the rear of the building, with a large lawn and a wheelchair-accessible summer house. A small parking area is situated to the front and side of the building.

A new home manager had just taken over from the registered manager and has since commenced their application to register. 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.

At our last inspection on 24 June 2014 we asked the provider to make improvements to their arrangements for people's care and welfare. This action has been completed.

Summary of findings

People and their visitors spoke highly of the care provided. Staff responded swiftly when people needed assistance. Care was based on a specialist model of dementia care and staff were trained in this. The assessments and care plans we saw were detailed and up to date, reflecting people's individual needs and histories. A health and social care professional commented that some care plans could be more up to date. Managers told us a project was still under way to rewrite care plans, which had now largely been completed. Staff knew about people's needs and people received the care they needed. People were supported to see healthcare professionals as needed.

Complaints had been investigated thoroughly, with detailed and transparent responses given to the person who complained, and an apology where appropriate. Actions were taken to address people's concerns, such as providing additional equipment.

People and relatives commented positively about the kindness of the staff. Staff had the training and support they needed to be able to support people effectively. Throughout our inspection staff communicated with people as adults rather than as patients who needed looking after. They treated people with compassion and respect, spending time chatting with them and assisting them in an unhurried fashion.

People felt that they or their loved one were safe. There were sufficient staff to meet people's care needs and appropriate checks were undertaken before new staff were employed. Staff were aware of how to report concerns about abuse. Medicines were managed safely.

The premises and equipment were regularly checked, cleaned and kept in good repair. Bedrooms were clean but there was a smell of urine in a corridor. We drew this to the attention of the management team and they immediately ordered a replacement carpet.

Consent to care and treatment was sought in line with legislation and guidance. The management team understood when people could be considered as deprived of their liberty and met their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS). DoLS ensure that care homes and hospitals only deprive someone of their liberty in a safe and lawful way, when this is in the person's best interests and there is no other way to look after them.

There was a choice of healthy, appetising food and special dietary requirements were catered for. Snacks were available between meals if people were hungry.

People, visitors, staff and health and social care professionals expressed confidence in the home's management. There was a warm, informal and person-centred culture, with people and managers having high expectations of staff. There had been changes to management and staff since the last inspection and morale had been low, but was starting to improve.

There was open communication with people, their relatives and staff and their views were used to develop and improve the home.

A system of quality assurance was used to drive improvements to practice. Areas for improvement identified by audits that covered all aspects of the service, as well as learning from accidents, incidents, safeguarding and complaints, were shared with staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were sufficient staff on duty to keep people safe and provide the care they needed. Appropriate checks were undertaken before new staff were employed.

The premises and equipment were regularly checked and kept clean and in good repair.

Medicines were managed safely.

Good

Is the service effective?
The service was effective.

People were cared for by staff who had the skills, knowledge and support they needed to perform their roles effectively.

Food was appetising. People had enough to eat and drink and special dietary needs were catered for.

People were saw doctors and other healthcare professionals when they needed to.

Good

Is the service caring?
The service was caring.

Staff treated people kindly and respectfully, as adults rather than patients who needed looking after. They spent time chatting with people and did not rush when providing care and support.

People's preferences were respected and their needs anticipated. When people needed assistance, staff responded quickly, providing the help and reassurance needed.

People's privacy and dignity were maintained. Visiting was not restricted.

Good

Is the service responsive?
The service was responsive.

People received the care they needed from staff who understood their individual needs. Care plans were kept up to date and reflected people's preferences and histories.

People had the opportunity to be involved in activities that were meaningful for them. These were arranged for groups and individuals by the home's activities coordinators and by external visitors.

Concerns and complaints were listened to, investigated thoroughly and used to bring about improvements.

Good

Is the service well-led?
The service was well led.

There was a warm, informal and person-centred culture. People and managers had high expectations of staff.

People and staff felt confident to approach managers who would address the concerns they raised.

Good

Summary of findings

Quality assurance included regular audits of all aspects of the service, as well as reviews of accidents, incidents and complaints. These were used to drive improvements to practice.

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.

The inspection took place on 23 and 26 June 2015. The first day was unannounced. The inspection was carried out by an inspector and an expert-by-experience on the first day and by a lone inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection cared for someone who lives with dementia.

Before the inspection we reviewed the information we held about the home, including notifications of incidents since our last inspection in June 2014. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. We also spoke with the local authority contract monitoring team.

During the inspection, we met most of the people living at the home, and spoke with 12 of them and four visiting relatives and friends. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not readily talk with us. We also observed staff supporting people in communal areas and to eat meals. We reviewed four people's care records, including their current medicines administration records. We also checked records relating to how the home was managed, including six staff files, the staff training database, the current staff rota and rotas for the past four weeks, maintenance records and the provider's quality assurance records. We spoke with four members of care staff, six ancillary and administrative staff, the new home manager, the previous home manager, the director of care and the provider. We requested feedback from other health and social care professionals in contact with people at the home and obtained this from five of them.

Good

Is the service safe?

Our findings

People and relatives told us they felt they or their loved ones were safe at Seabourne House Care Home. For example, a relative commented, "I feel that [my relative] is safe when I'm not here". A person told us how measures were taken to keep them safe: "I'm accident prone. I have fallen flat on the floor but there is a mat". Another relative commented that measures were taken to protect their family member from falls: "When I'm not here I know the equipment is in place. If they roll off the bed a mattress is in place, there is an alarm. There have been no problems".

People were kept safe by staff who were aware of how to respond to and report concerns about abuse, including knowing how to inform outside agencies. The management team had responded appropriately to safeguarding concerns since the last inspection and had cooperated with the local authority to resolve safeguarding investigations.

Closed circuit television (CCTV) had recently been installed in communal areas as an additional measure to protect people, following consultation with relatives and staff. This was due to come into operation shortly after the inspection. The provider had heeded the Commission's guidance for providers on using surveillance.

Risk assessments and management plans were kept under review, in relation to both individual people's care and for the home generally. There was an emergency contingency plan detailing the measures to be taken in the event of serious incidents such as fire or the failure of power or water supplies. An outside contractor had undertaken a fire risk assessment within the past year and there were weekly fire alarm and emergency lighting tests and checks of the evacuation routes and fire doors. Accidents and incidents were recorded and reviewed by managers for any immediate action needed to reduce risks. They were also analysed for any trends that indicated a need for changes in practice.

There were sufficient staff on duty to keep people safe and provide the care they needed. In addition to care staff, the provider employed activities coordinators, kitchen staff, cleaning and laundry staff and an administration and management team. Staff told us they enjoyed their work.

Although staff were busy, they were not rushed when supporting people. Staffing levels were monitored by managers and adjusted according to the numbers of people living in the home and their dependency.

There had been a turnover of staff since our last inspection. New staff only started working unsupervised after the required checks had been undertaken, including references and Disclosure and Barring Service criminal records checks.

Medicines were managed safely. Medicines were stored securely and there were appropriate arrangements in place for recording them. We checked some medicines and the amount in stock tallied with the medicines records. Medicines administration records (MAR) were mostly pre-printed and contained people's photographs and details of any allergies. Staff had initialled MAR to record medicines given as prescribed or had recorded the reason why a medicine had not been administered. Medicines applied topically, such as creams and ointments, were recorded on a separate MAR for each medicine, with instructions and body maps showing which area of skin the cream was to be applied to. Staff who administered medicines were trained to do so and their competency was checked periodically. To reduce the risk of medicines errors, the member of staff responsible for administering medicines wore a 'do not disturb' red tabard.

The premises were regularly checked and maintained in good repair. There were in-date contractors' certificates for gas and electrical safety. Legionella control was overseen by an outside contractor and there were regular water temperature checks and flushing of water outlets. (Legionella are water-borne bacteria that can cause serious illness). The maintenance person confirmed they had the resources they needed for repairs. One of the corridors smelt of urine and another of the corridors had a sticky carpet. We drew this to the attention of the management and they straight away ordered replacement carpet. A satisfactory environmental health check earlier in the year had remarked on the condition of the kitchen flooring, which had some cracks. The management team confirmed there was a plan to replace this. Some wardrobes were not attached to walls and wobbled when we pushed them. We drew this to the attention of the provider and they confirmed following the inspection that wardrobes had been checked and secured.

Good

Is the service safe?

Equipment, such as moving and handling hoists and slings, was provided to maintain people's safety and was regularly serviced. Adjustable beds had been provided since the last inspection in June 2014. Hoists were checked by a specialist contractor six monthly.

The home was kept clean and arrangements were in place to control the spread of infections. A regular visitor commented, "The cleaning never stops… If there is a mark on the carpet it is cleaned straight away". Cleaners were busy throughout our inspection and, although there was a smell of urine in one of the corridors, people's rooms were clean and tidy with only pleasant smells. Sluice rooms had been refitted to aid cleaning. Cleaners told us they had sufficient time and equipment. Cleaning equipment was colour coded for use in designated areas, such as kitchens and bathrooms. Cleaning schedules set out what needed cleaning and when, and cleaners confirmed they were aware of the routine daily and additional tasks, such as deep cleans, expected of them. There were separate cleaning schedules for the kitchen, which kitchen staff completed after undertaking the tasks listed. There were adequate supplies of personal protective equipment, such as disposable aprons and gloves. During our observations staff used this appropriately.

Good

Is the service effective?

Our findings

Those people who were able to articulate it expressed satisfaction with their care, as did people's relatives. For example, a person's visitor told us the person was "well cared for, clean and gets turned".

Staff had the skills and knowledge they needed to care for people effectively. There was an eight day induction for new care staff, much of which was attended by new ancillary staff also. This covered topics such as safeguarding adults, fire safety, infection control and moving and handling, and included dementia awareness. It was aligned with nationally recognised standards for care workers and staff were expected to complete the care certificate. Staff had to complete refresher training every year to two years in most of these areas. They were supported to obtain diploma qualifications relevant to their areas of work. They also had more in-depth training in the model of dementia care adopted by the home.

Staff were also supported in their roles through regular supervision meetings to reflect on their work with a more senior staff member.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They ensure that care homes and hospitals only deprive someone of their liberty in a safe and lawful way, when this is in the person's best interests and there is no other way to look after them. They require providers to apply to a 'supervisory body' for authority to deprive someone of their liberty. The management team understood when people could be considered as deprived of their liberty. Where necessary they had applied to authorise deprivations of liberty and there was a system for reviewing and applying to renew the authorisations.

Where people lacked the mental capacity to make decisions about aspects of their care, staff were guided by the principles of the Mental Capacity Act 2005 to make decisions in the person's best interest. Even where people not able to make decisions for themselves, care plans recorded that they had been involved as far as possible and gave guidance for staff about any support the person needed to communicate. Best interest decisions were made on the basis of the least restrictive intervention necessary.

People said the food was good, with plenty of choice and that anything they disliked would be changed. One person said, "Good selection, I have a choice. Anything I didn't like they'd take it back and bring something else". Another said, "It's very good" and a further person described their meal as "tasty and lovely".

Food was attractively presented on coloured plates, which research has shown makes it easier for people living with dementia to eat. Kitchen staff showed us how they moulded pureed food, for people who needed this, into the shape of the food to make it as appetising as possible. People who chose to stay in the lounge area were encouraged to eat at dining room tables, which had been laid for the meal.

There was a rolling menu for lunch and supper, with a choice of two starters and main courses at lunch and two types of sandwich or a cooked meal in the evening. Staff helped people select their meals in advance by showing them coloured photographs of the meals. If people did not like either option the kitchen staff would prepare something else they wanted. The kitchen staff had lists of people's dietary needs and preferences and confirmed they were kept informed of any changes.

Food and drinks were available between meals. People used 'snack stations' in communal areas, with fresh fruit and packets of crisps or biscuits. Home-made cake was served with afternoon tea. There was a choice of hot and cold drinks. Where people had particular eating and drinking needs, staff monitored and recorded how much they ate and drank. Fluid monitoring charts contained target amounts and were totalled to help staff ensure the person drank enough. Action was taken in event of unplanned weight loss, such as contacting the GP and seeking referral to a dietician or giving prescribed food supplement drinks.

People saw healthcare professionals when they needed to, including doctors, district nurses, community mental health nurses, physiotherapists and speech and language therapists. There was a visiting dentist, optician and chiropodist. Those people who were able to articulate it, stated they were very satisfied with their healthcare. One person said, "The doctor [who comes here] tells me all about what they're [medicines] for". Healthcare professionals said that staff responded to health issues appropriately and followed instructions. Two professionals described staff as 'proactive' in seeking healthcare advice

Good

Is the service effective?

and support. One professional commented that in recent months staff had worked more effectively than previously with the mental health team to support people who demonstrated behaviours that challenge others.

The environment had been adapted according to the needs of people living with dementia. Bedroom doors were decorated to help people recognise their rooms, and bathrooms and toilets were also easily identifiable because of prominent signage. Corridor handrails and flooring contrasted in colour with the walls to help people distinguish the difference and make it easier for them to move around. A portable ramp was available to help people get out into the garden more easily. Outside there was a decking area and a lawn with a selection of garden furniture, as well as a furnished summer house accessible by a ramp.

Good

Is the service caring?

Our findings

People commented on the kindness of regular staff, although some remarked that there had been staffing changes. A person who had sore skin told us, "All the staff I know are kind. They are gentle; they have to be with me". Another person told us, "I haven't heard of any squabbles or anything. They are kind, everything's fine". Another said, "It is friendly but it depends on you; if you are pleasant to people, you get the same back". A further person described staff as "Very kind, the majority. One or two are absolutely perfect". A relative said, "My [relative] died here. All were very kind to me… I've no complaints. There are one or two exceptions but staff are generally kind". Another relative told us, "I feel welcome here, it's one of the plus points". They also said, "Staff have changed a lot this year. A lot of foreign staff have gone but staff of different nationalities get on so well. All staff are good with lots of empathy. One or two agency staff are not so good."

Staff were observant and anticipated people's needs. For example, one person was being assisted to eat lunch and was chatting with the staff member. When they had finished the member of staff asked if they would like to lie back. The person replied, "Yes, lovely. You're very helpful". Similarly, after lunch a staff member asked a person, "Shall I put some music on? Your CD?". The person answered "Yes please" and settled down to listen.

Throughout our inspection staff treated people with compassion, communicating with them as adults rather than as patients who needed looking after. They explained what was happening, such as telling people that lunch was nearly ready. Staff, including cleaning and laundry staff, were busy but spent time in conversation with people. When people needed assistance, for example with moving about or with eating a meal, staff supported them at their own pace without hurrying. When people asked for help or became upset or disorientated, staff responded promptly to assist and reassure them, in a calm and natural way.

People's interests and preferences were acknowledged and acted upon. For example, a relative commented, "Music means so much to us. I can tell they are listening to the CD I brought in". Another person said they loved dogs and had a book about dogs close to hand. A further person decided they fancied eating some bread and cheese instead of the items on the lunch menu and this was brought to them.

There were no set visiting times and visitors could come and go as they wished. Relatives and friends were involved in people's care to the extent they wished to be and were kept informed about any changes. For example, a relative said, "I go through the care plan at any time to refresh myself. I keep myself informed and if anything is amiss I'm told". A relative explained how they had valued support from a particular member of staff to complete a continuing healthcare funding application.

People's privacy was respected and they were treated with dignity. One person said that staff "maintain privacy if doing treatment – they shut the door", although another commented that when medicines were brought round this was "not private". All personal care took place behind closed doors. When people needed assistance with personal care matters, staff attended to this discreetly. A health and social care professional who visited the home regularly commented, "I have never witnessed residents being treated with anything other than respect".

Good

Is the service responsive?

Our findings

At our last inspection in June 2014, care plans were not all up to date. A person's risk of malnutrition had been incorrectly assessed, which meant they had not received the care they needed such as a fortified diet. The air mattress on their bed was not correctly adjusted, increasing the risk of the person developing pressure sores. Care and treatment was not always delivered according to people's care plans. People who needed assistance with repositioning to reduce the risk of pressure sores had not always received assistance as often as their care plan said they needed. People had not always had their prescribed creams and lotions applied, or staff had sometimes failed to record when they had applied these.

Following the last inspection the provider sent us a detailed action plan setting out their actions to address the concerns regarding people's care and welfare and kept us informed of their progress with this.

At this inspection in June 2015 we found there had been improvements to the planning and delivery of people's care.

People and their visitors spoke highly of the care provided and said that staff responded promptly when they needed assistance. For example, one person said, "Staff are very amicable, you can rely that they will help you if they can". Others said, "If there is a problem, someone would come alright" and "I would call one of the assistants – they would help. If you press the bell they come straight away". Our observations confirmed this. People did not call out for long periods and call bells and alarms were responded to swiftly.

Care planning and delivery was based on a specialist model of dementia care. Assessments and care plans reflected people's individual needs and were kept under review. People's needs had been assessed before they moved in, to ensure Seabourne House Care Home could meet them. Further assessments were undertaken once people arrived, including using recognised risk assessment tools to assess the risk of pressure sores and of malnutrition. Assessed needs were reflected in care plans that were detailed and personalised, recording people's history and preferences. Assessments and care plans addressed issues that would be expected in a care setting. These included personal care, physical health, psychological needs, communication, medication, nutrition, moving and handling, skin and pressure area care, and night time needs. There were separate plans for specific issues such as diabetes and swallowing difficulties. Where necessary specialist professional advice had been obtained, such as speech and language therapy assessments of swallowing difficulties.

A health and social care professional who regularly visited the home commented that "care plans could do with a bit of updating". Many care plans had been rewritten recently as part of a drive to improve care planning. The care plans we saw were up to date, but the management team acknowledged that rewriting care plans was a work in progress.

People received the care they needed. Staff were familiar with people's needs and followed their care plans. People were neatly groomed, which showed they had received any support they might have needed with their personal hygiene. Where people were at risk of skin breakdown and had difficulty moving themselves, records showed they had received assistance to reposition at the correct intervals. Where people needed air mattresses to reduce the risk of developing pressure sores, there was a system of regular checks to ensure these were set correctly.

People chose whether they wished to be in the downstairs lounge and dining room, or in or around their bedrooms, and staff were arranged to accommodate this. A person told us, "I'm in my room all the time because I'm very sore, mostly asleep… I don't particularly want to go downstairs. I don't get dressed in the daytime – I'm very sore. I do well here, they are very good to me".

People had the opportunity to be involved in activities that were meaningful for them. People told us there were things to do if they wanted. For example, a person said, "I don't like art or bingo. I'm happy watching TV but like to go out and I like the music". Another said, "I like TV. Sometimes people come in – that's alright". A further person said, "I don't particularly like TV but there's nothing else to do. I do art". A person who needed assistance to move around said they had regular opportunities to go outside. There was an activities coordinator and an activities assistant, who facilitated group activities such as artwork. They also worked with people on an individual basis, where people preferred to stay in their rooms. There were also regular activities provided by outside visitors. For example, during

Good

Is the service responsive?

the inspection, a chaplain led a service and someone else came in to do manicures. By arrangement, the chaplain was spending longer at the home than they did in 2014, in order to minister to people in their rooms.

Concerns and complaints were listened to, investigated and used to bring about improvements. Relatives expressed confidence that they could raise concerns with managers, who would do something about them. One said, "There is a day book with a section for complaints/ concerns, otherwise I would go to the desk or office." There had been seven complaints since our last inspection, although these were outnumbered by compliments. The complaints had all been acknowledged and reasons given for any delay. Six of the complaints had been investigated thoroughly, with detailed and transparent responses given to the person who complained, and an apology where appropriate. The other complaint was in progress and the person who had made the complaint met with the director of care. Some action had already been taken in response to the person's concerns. For example, the lounge furniture had been rearranged and a portable ramp provided to make the back garden more easily accessible by wheelchair. Other improvements as a result of complaints included additional staff training in the Mental Capacity Act 2005.

Good

Is the service well-led?

Our findings

People, visitors, staff and health and social care professionals expressed confidence in the home's management. There was a warm, informal and person-centred culture, with people and managers having high expectations of staff. For example, one person spoke about the staff being "genuinely happy and caring" and described them emphatically as "dedicated". Staff did not wear uniforms, which reinforced the informality, although one visitor questioned how people living at the home would know who was who. A member of staff who had recently returned to a role at the home remarked that, in a positive way, the home was "so different to how it was". A new member of staff, who had worked at other care homes, said their faith in care work had been renewed. They commented that managers were supportive and "even clean toilets if needed". Staff were aware of how to blow the whistle about poor practice to outside agencies, but felt they could approach the management team with confidence they would act on any concerns raised.

There had been a movement of staff and changes in management since our last inspection. The management team recognised that staff morale had been low but was beginning to improve. This was reflected in a recent staff survey, where amongst positive feedback there had been some adverse comments about teamwork and fair division of responsibilities. There was a plan in place to address this.

The manager, whose first day in post coincided with the first day of our inspection, was not registered with the Commission but confirmed they would apply to register. They had been promoted from another post at the home, and their predecessor continued to be employed in a different role. A visitor commented that the new manager was "steady, serious and will have the help of the previous manager". Support had been arranged for the new manager, from both the director of care and from an external supervisor.

Having a registered manager is a condition of the home's registration. 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. The home's managers had notified us of deaths, serious injuries, abuse or alleged abuse and other incidents as required by the regulations.

There was open communication with people, their relatives and staff and their views were used to develop the service provided. Residents and relatives meetings and staff meetings took place every three months or so. There was a rolling quality assurance survey programme, where a proportion of people and families received a quality assurance questionnaire each quarter, such that everyone received one in the year. The responses received were analysed and where necessary an action plan was developed. The responses to the most recent survey, which focussed on cleanliness, were all positive. There had been separate consultation regarding the installation of CCTV in communal areas and changes had been made as a result, such as to the colour of the cameras in the corridors so they looked less obvious.

People, relatives and staff were also able to speak with managers individually. One regular visitor with a relevant background had volunteered to set up a relatives' support group. The management team were supporting this and had organised for the person to have a Disclosure and Barring Service check to ensure they had no history of criminal offences that would make them unsuitable to run the group.

A system of quality assurance was used to drive improvements to practice and the management team considered how the home could be developed further, such as developing further links with the local community. There was a programme of regular audits, which had been overhauled in response to the difficulties found at our inspection in June 2014. Audits addressed all aspects of the service, including maintenance, cleaning, medicines, care planning, meals and staff recruitment. Areas for improvement identified by the audits, as well as learning from accidents, incidents, safeguarding and complaints, were shared with staff as necessary. This happened through individual meetings or supervision, staff meetings, handovers or written communications.