Seymour Court Care Limited

Seymour Court Nursing and Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Seymour Court Nursing and Care Home ("Seymour Court") was inspected on the 2 and 3 October 2018 and was unannounced. This is the service's first inspection since registering with this provider on the 6 October 2017.

Seymour Court provides care to older people who require residential support with nursing. The service is registered with us to provide care for 34 people who may be living with dementia, a physical disability and/or a sensory impairment. There were 32 people living at the service when we inspected.

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

People's accommodation was within a converted building spread across three separate floors. There were some double rooms where people were supported to share with someone who was compatible to them. There was a family room for people to stay in should they be needing to be with a relative that was at their end of life.

A registered manager was employed to oversee the service locally. 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. They were supported in this role by a clinical lead and two care managers.

We found external area of the service had not been assessed in respect of security and keeping people safe from falls and trips. Also, not all aspects of people's medicines were managed safely. These issues had not been identified by the provider's own quality assurance processes. We raised these concerns with the service who began to take action to address them.

People told us they were safe and happy living at Seymour Court and were looked after by staff who were kind and treated them with respect, compassion and understanding. The provider, registered manager and staff were working towards a high level of improving the experience of people living at the service. All staff expressed a commitment to values of providing only good care and to continue to improve the service.

The service was moving towards specialising in end of life care. We saw compliments from family that demonstrated they were achieving good end of life care for people. An example of the feedback was, "I cannot fault the care the staff gave to my mum during the week she was [at Seymour Court]. Sadly, it was a short time for end of life care; nothing was too much trouble. All her children were able to stay with her and they also looked after us."

People felt in control of their care. Their care was planned with them or their relative. A detailed personal history was taken to reflect the person; this was used to support people to have their desires met in life so they could pass away having achieved something they always wanted to. If this was not possible, the information was used to enable the person to die having their wishes and feelings met. No everyone was having the Accessible Information Standards applied to ensure they had their communication needs met. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

People could see other health professionals as required. People had risk assessments in place so they could live safely at the service. These were clearly linked to people's care plans and staff training to ensure care met people's individual needs.

Staff knew how to keep people safe from harm and abuse. Staff were recruited safely and underwent training to ensure they were able to carry out their role effectively. Staff were trained to meet people's specific needs. Staff promoted people's rights to be involved in planning and consenting to their care. Where people were not able to consent to their care, staff followed the Mental Capacity Act 2005. This meant people's human rights were upheld. Staff maintained safe infection control practices.

Activities were provided that reflected the needs of the individual. Group times were available but the time was mostly one to one. For people at their end of life, the importance of touch, the voice and ensuring the person could sense someone was there were taking place.

People were accepted for who they were regardless of identity, with every effort that everyone, regardless of their sexuality, faith, culture and ability, could end their days in an accepting, open culture where tolerance for all was practiced.

People's complaints were taken very seriously and every effort made to ensure all concerns had been identified. Reflective practice was a central theme that demonstrated how the service aimed to learn from every event and emotional reaction to it. This meant the service was continually learning from events.

People, relatives and staff were involved in giving feedback on the service. They felt it was easy to approach the registered manager and/or provider. Everyone felt they were listened to and any contribution they made was taken seriously. Regular audits made sure aspects of the service were running well. Where issues were noted, action was taken to put this right.

We found a breach of the regulations. You can see the back of the full report to show what action we have told the provider to take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The external area of the service had not been assessed in respect of security and keeping people safe from falls and trips.

Not all aspects of people's medicines were managed safely.

People had individual risk assessments in place to keep them safe.

People's needs were met by sufficient numbers of staff that were recruited safely.

Infection control procedures were followed.

Incidents and untoward events were reflected on to ensure lessons were learnt.

Is the service effective?

Good

The service was effective.

Staff were trained to effectively carry out their role.

People's health needs were met and staff worked closely with a range of health staff to achieve good outcomes for people.

People were provided with a good diet and kept hydrated.

People had their right to consent respected and were assessed in line with the Mental Capacity Act 2005 as required.

People were assessed on enquiry or before coming into the service to ensure their needs could be met fully.

People were involved in choosing how to refurbish the premises.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and had their dignity protected.

People were supported by staff who were kind, considerate and made sure people's emotional welfare needs were met.

People and relatives were given the opportunity to comment on the care received

Is the service responsive?

Good

The service was responsive.

People had their end of lives support needs were met so they died with dignity and pain free.

People had personalised care in place.

People's concerns and complaints were dealt with quickly and thoroughly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance process had not identified the issues we identified in the safe domain.

People, staff and relatives were involved in the running of the service.

People, staff and relatives told us the registered manager and provider were accessible and responsive.

The registered manager and provider ensured a culture of improvement, learning and innovation.

The service worked closely with other agencies locally.

Seymour Court Nursing and 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.

Seymour Court Nursing and Care Home ("Seymour Court") was inspected on the 2 and 3 October 2018 and was unannounced. This is the service's first comprehensive inspection since registering with this provider on the 6 October 2017.

The inspection was carried out by one inspector, one specialist nurse advisor in the care of older people and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held on the service. This included their registration, notifications we had received and their Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. A notification is information about important events which the provider is required to send us by law.

During the inspection, we looked around the inside and outside of the premises. We reviewed the care of eight people in detail and spoke with them where we could. We also spoke to 18 other people, 11 relatives and two professionals linked with the service. We left questionnaires for any feedback others wanted to give us and we received two back. These were from one family and one health professional.

We also read the personnel and supervision records for five staff and the training records for the service. We spoke with 10 staff. The registered manager, clinical lead, area manager and provider all attended and

supported the inspection. Their view was sought about various aspects of the service.

We reviewed records held by the provider and registered manager in respect of how they ensured the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

There was no risk assessment of the outside space. When we stepped outside the rear of the premises, we observed there were many trip hazards, a fall from height with no barrier and an unstable walking surface that had not been made safe. All other areas had a number of steps to negotiate. Steep stairs down to the basement were also fully accessible in more than one place. The garden at the front had an uneven walkway which would be difficult for people with poor balance or needing to use a walking frame or wheelchair to use on their own. No area had been assessed as to the need for handrails to support those who were ambulant but needed a little support to be safe.

Access to the rear area also required people to step over or have their wheelchair tipped to go over the lip of a double-glazed doors. This presented a trip hazard and meant people could not access the space freely without staff being on hand.

Inside, risk assessments had been made in respect of some areas but not in respect of the use of the corridors and down steep steps to the basement. This again meant areas had not been viewed for their safety aspect and what reasonable adjustments needed to be made to support people to move about the service.

There was also a gate at the rear of the property that led to the street which was unlocked and constantly open. Doors to the rear of premises were also unlocked, which meant members of the public and visitors could walk in freely. This meant the security of the premises could not be assured.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager, area manager and provider about the outside space. They started to put immediate safety measures in place. Barriers to protect people from the most harmful drops were in place by the end of the first day. The back gate was locked with a contractor booked to fit an intercom, as this gate was the level access for people, families and ambulances. By the second day, plans were being put in place for other contractors to make and fit gates and safety barriers that could be utilised to keep people safe.

The provider advised that having taken over the service twelve months ago, they had concentrated on the inside of the building which needed a lot of work to ensure it was safe and a pleasant place to live. There were plans for the outside but these had not yet been addressed to ensure they were safe.

Aspects of the management and recording of people's medicines required improvements. People's 'as required' medicines such as for the relief of pain, showed that people were being given these as routine. The service used pain scales when 'as required' medicines were needed, but there was no additional evidence

this had been discussed with the person's GP to review why the use of pain relief was needed so often. We spoke with the clinical lead about reviewing 'as required' medicines to ensure they are following current guidance as required by NICE (The National Institute for Health and Care Excellence).

People's prescribed creams were applied but were not being recorded as being so. People's medicine administration records (MARs) were left blank and there was no other way to ensure a record was kept. We were told by the registered manager that staff should be completing a record and steps were taken to ensure these were now being completed. Following the inspection, the provider has advised the care plans were put into people's rooms; the application of the prescribed creams is being recorded and signed for accordingly.

We also identified that there was no record on the MARs when someone was administering some or all their medicines. For example, a person who administered their own inhalers was not having their use monitored. When we spoke with the person, they reported "using it regularly" but as there was no appropriate care planning to describe their expected use, it was not possible to gauge if they were correctly or over or under using their inhalers. This meant a sign that further review is needed could be missed.

One person, living with diabetes, MAR had been amended. The MAR held a printed record of the type of insulin in use, but the actual dose was handwritten with no signature and no date to why this was added. Underneath, handwritten it stated, "do not give if blood sugar under 4", but this instruction was again unsigned and undated. As this is a fluctuating factor, it was not possible to be assured all staff were ensuring the correct dose of insulin was being given. There was then no additional record that stated where the changes had come from and that they were the current, up to date requirement of the prescriber. Also, their typed MAR stated there was a need to administer insulin after breakfast, but within their care plan it stated to administer before breakfast. This meant the records, and therefore the instruction to staff, did not correspond and could lead to an error occurring. The person's blood reading machine had not been checked for ongoing accuracy which could impact upon possible insulin requirements.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's other routine oral medicines were administered, stored and disposed of safely and in line with current guidance. People's medicines were ordered in good time. Staff who had the role of ordering and checking in medicines had time to complete the tasks safely. People confirmed their prescribed creams were being used as needed and their care plans detailed what cream should be used, where and when.

People could self-administer all or part of their medicines if desired. Risk assessments and reflection on the Mental Capacity Act 2005 were in place with regular reviews to check this remained safe and appropriate. A clear record was kept of when these medicines has been given.

All nursing tasks, such as applying dressings and giving injections, were completed by the nurses or by members of the community nursing team. The service however, was utilising senior health care assistants to give medicines. We found that there was a need to ensure there were clearer lines of accountability and competency checking to ensure these staff understood the full range of their responsibilities. There was no current assessment of their knowledge and in discussion with them we found they lacked a rounded knowledge base and were not able to fully reflect current guidance. There also needed to be more reflection on whether the administration of medicines by non-nurses was being covered by the Scheme of Delegation (as laid down by the Nursing and Midwifery Council) or was an independent action by the care assistant. The

communication we had with different staff gave a confused picture which meant all staff were not clear on whether they were supporting the nurses or acting within their own authority.

People had a range of risk assessments in place to support them to live safely while residing at Seymour Court. These covered the risk of falls, their skin breaking down, malnutrition and any individual risk that may increase their risks. These were then clearly linked to their care plans. Health issues such as those associated with diabetes were clearly recorded with details on how staff could keep that person safe. We identified that the risk of choking was covered in people's care plans with professional support sought from the person's GP, Speech and Language Team (SALT) however, there was no standalone risk assessment to monitor the effectiveness of this. By the end of the second day of the inspection action was taken by the clinical lead to identify all those who required a risk assessment. This meant people already with SALT guidance in place or nursed in bed, for example, would have their needs reviewed to be assured their risk of choking was being mitigated.

We observed that people's "thick and easy" products had been held in their rooms and were freely available. This was placing people who could not understand the risk of choking posed by oral consumption at risk. We highlighted the concerns about this to the registered manager and they were removed from being easily accessible.

Personal Emergency Evacuation Plans (PEEPs) were in place to be used in the event of a whole home evacuation. There were regular checks of the environment and the equipment people used. For example, air mattresses and water temperatures were checked to ensure people were not put at risk.

Everyone said they felt safe living at Seymour Court. One person said, "I feel safe because there is always someone around which is reassuring for me" another said, "Staff are constantly looking out for me which makes me feel safe" and a third said, "It's reassuring having the bell and that staff come if you need them".

All relatives said, they considered their relative to be safe living at Seymour Court. Relatives said: "My wife is absolutely safe here she has her buzzer and can call staff anytime"; "I can go home from here and don't worry about mum because I know she is safe and well cared for"; "Mum is 100% safe and happy here and we've never had a moment of worry" and, "I never leave here with a feeling of uneasiness because I'm sure in the knowledge that my loved one is well looked after".

Staff demonstrated they understood how to identify if they had concerns about people's safety. Staff said they would have no hesitation in reporting any concerns to the clinical lead and registered manager. They were confident that action would be taken to protect people. All the professionals we spoke with were positive about the home's approach for keeping people safe.
One staff member said, "I would speak to [the registered manager] if I had a concern or [the clinical lead or provider]. I have no concerns that they would not act. I understand how to whistle-blow otherwise."

People and relatives said they knew who to talk to if they had any concerns. People said, "If I have any concerns would talk to the manager"; "I would ask one of the staff who's the best person to talk to" and another said, "I could talk to anyone about any niggles I have". One relative said, "I would talk to the manager if there was a problem and I know it will be sorted" and another said, "I've talked to the owner and the managers when I've need to because they are so approachable".

The risk of abuse was reduced because there were suitable recruitment processes followed for new staff employed. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been

obtained. Staff were recruited carefully to ensure they had the right values for the service. People who lived at the service were included in the recruitment of new staff. Staff signed annually that they had not been convicted of any offences that could put people at risk and had their backgrounds reviewed every three years to ensure their DBS (Disclosure and Barring Service) remained clear.

People were supported to be themselves while living at the service. Staff were welcoming to everyone to ensure people could practice their faith, for example. Staff got to know people and ensured they were safe from any negative impact due to their beliefs, sexuality, race or disability.

The service was staffed safely. People, relatives and staff all described a service that was staffed in line with the current needs of the people living there. Staffing was flexible according to people's dependency.

One person said, "My call bell gets answered quickly so there must be enough staff around" and a relative said, "There's a good number of staff here". One person mentioned "I notice from time to time they are a bit short staffed so they call someone in".

People's accommodation was kept clean and the kitchen, domestic and laundry staff followed safe infection control practices. Staff who delivered care used gloves and aprons as needed. Clinical waste was disposed of in the correct yellow bags and bins. The outside clinical bins, however were unlocked but have now been secured. We were also told that people had shared hoist slings, slide sheets and handling belts that need to have their own cleaning programme to keep people safe from cross contamination.

Everyone said the service was clean. People said, "It's brilliantly clean"; "It's so nice and clean and the cleaner is so friendly" and another, "It's very clean and tidy here and no smells". One relative said, "Mum's room is always kept very clean as is her bathroom" and another said, "its spick and span and no nasty smells".

The registered manager and staff ensured they learnt from events. Reflective techniques were embedded in practice at the service. This meant incidences and concerns were looked at in detail and shared so learning could be taken forward.

Good

Is the service effective?

Our findings

People and relatives said that the staff were well trained. People said, "They help me in so many ways"; "The staff are very good, they support me with getting out of bed and having a wash and they never rush me" and another, "Staff are very understanding – if I need a wheelchair they will see to it for me". One relative said "They are as good as gold with mum helping her with so many things" and another, "I'm absolutely happy with all they do for my wife".

New staff underwent an induction to understand how to meet people's needs. People said they were routinely introduced to new staff. One person said, "New people are introduced to me when they join here" and another, "The manager or next one in command introduce new staff to me".

Staff told us they felt they had a good level of training and input to maintain their ability to meet people's needs. Staff told us they had training in respect of dementia care in June which they had found helpful in understanding the needs of people living with dementia. One staff member said, "If I need anything, have any questions, the managers will respond. I can't fault them."

Staff had regular supervision and were encouraged to reflect on their practice, incidents and events. The emphasis was on supporting staff to be fully effective in their role. Times were set aside in team meetings and in short bursts to capture learning and remind staff of best practice. The registered manager advised this was to continually ensure staff were meeting people's needs from having the latest, up to date knowledge.

Not all staff training records were available immediately for this inspection. This was due to some being lost when the service was in administration prior to the new provider have taken over the service in October 2017. A new record of staff training had been created, but showed gaps in essential training. However, plans were in place to address this with training arranged for the weeks following the inspection. Training courses were planned in November 2018 for "Manager's Infection and Prevention Control" and caring for people living with dementia.

On the 15 October 2018 the registered manager advised, "I have immediately taken steps to rectify [the training]: first, by reorganising the training matrix, and secondly, by ensuring any staff who are missing up to date training were immediately booked into either e-Learning, or onto the upcoming training we have booked (starting from next week, over the course of two weeks). Staff who have been instructed to complete any missing e-Learning courses have been given the deadline of next Sunday, meaning that nearly all training will be up to date within the fortnight."

The PIR stated, "All Staff: Fire Safety; Infection Control; Manual Handling; First Aid; Food Awareness; Food Hygiene; Dementia Awareness; MCA Training; Safeguarding. All staff are currently in the process of completing mandatory training via the E-Learning portal. Management Led Workshops, undertaken weekly to all staff: Duty of Candour; Institutional Abuse; Whistleblowing; Rights and Choices. Nursing Staff: Syringe driver; Venepuncture; Verification of Death; Tissue Viability; Wound and Pressure Ulcer Dressing; PIN

revalidation Management; Six Steps (end of life care); Safeguarding alerters (Management Level)."

We checked the service was working within the principles of the Mental Capacity Act 2005 (MCA) and conditions on authorisations to deprive a person of their liberty were still being met. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and all staff understood how the MCA applied to their work. People's right to consent to their care and treatment was constantly reviewed and their human rights respected. People's consent to share a room and their overall care was recorded. People were given every opportunity to consent to their care and treatment and the staff ensured people had the right to think about this and what was best for them. Staff supported people to make choices about what they wanted to do with their day.

People had their capacity to consent to their care and treatment assessed in line with the MCA and DoLS was applied for as required. Best interests decisions were made with family and relevant professionals. People's care plans detailed what staff had to do for people when they could not consent. Appropriate professionals were consulted and DoLS applications made for people who required this to keep them safe. Some DoLS were awaiting authorisation but staff ensured they put in place the least restrictive practice to ensure people could be free to go out with support of staff. Staff told us how independent assessors (IMCAs) were involved in people's care and they could consult these or other professionals if they needed to understand an individual's needs better.

The PIR stated, "We work within the framework of the Mental Capacity Act, therefore sometimes we have to deprive a service user of their liberty. In these instances, all appropriate measures are taken, multidisciplinary teams are involved, and all decisions are made in the best interest of the service user."

People had their health monitored to make sure they were seen by healthcare professionals to meet their specific needs as required. Six monthly reviews with their GP were standard, thus maintaining strong links with GPs and relevant agencies. There was involvement from a range of health staff to assess and give advice and guidance on people's needs. The service admitted people moving from hospital to home. People were supported to rehabilitate and regain confidence in, for example, walking safely with the required equipment. The health professionals told us there was a close working partnership to achieve the person going home fully able.

People praised the quality of the food and said they could make choices about the food offered. Where there were concerns about a person's nutritional needs, people had food charts fully completed to monitor their intake. Meals were provided in accordance with people's needs and wishes. The staff followed advice given by health and social care professionals to make sure people received effective care and support. Special diets were catered for. Staff went that extra mile to ensure people had exactly what they wanted to eat at that time. Staff told us they would notice if someone's food had not been eaten and would check why. Along with offering something else, they would check to see if this was something the person did not like. Special efforts would then be made for that person.

One person said, "There is a good choice of food" and another, "The food is brilliant – plain and simple just as I like it".

We observed that people either ate their lunch sat in the lounge or in their rooms. A member of staff was observed very caringly and patiently supporting two people to eat some food and to have a drink. The staff

member chatted to the people and said, "I'll go and get you some ice-cream as I know you like that" to one person.

People were given regular drinks. We observed staff offering drinks to people throughout the inspection and people could have a drink when they needed one. However, we found that although the care plan detailed how much people should be drinking, this was not carried forward on to the monitoring records kept; what people had drunk was not being matched to their expected level. This meant what people had drunk was not being reflected on to spot any issues. We spoke with the registered manager and clinical lead who started to ensure this was put right. This meant they would then be able to identify those who were not drinking enough to keep them well.

One person said, "I get plenty of orange juice and hot drinks throughout the day" and another, "They fill up my jug and cup so I can have a drink whenever I want".

The service assessed people carefully before or as they moved into the service; the aim being to ensure they could provide for the full needs of the person. This included being aware of people's cultural, sexual and social identity as well as any disabilities that they needed special equipment for. This information was gathered over time. One to one times with registered manager followed on from the initial assessment, to support people feel comfortable in sharing what personalised care would mean to them. This meant one person had been able to discuss their sexuality with staff and how the service could meet their needs. They told us, "I feel accepted here."

Staff worked in partnership with other professionals to ensure that their skills were constantly developed. For example, the Clinical Lead worked with other health professionals in the community. The registered manager worked with the local hospice and other clinical and mental health units locally. They had developed links with the local acute hospital and hospice to develop their end of life care. This was to ensure they were up to date with current practice guidance.

Following the inspection, the provider has advised that staff from the service also attend the continence link meeting; tissue and wound interest group; nurse forum; ambassadors for care and health and well-being champions group.

The building had undergone a programme of repair and refreshing of the environment. This was ongoing. People were involved every step of the way to make the changes right for them. They had chosen the paint and fabric used, for example.

Good

Is the service caring?

Our findings

People and relatives were positive about how caring the staff were. All spoke highly of the staff. People said, "They look after me nicely and are really friendly"; "Nothing is too much bother they are so kind"; "I like living here because everyone is so friendly and that makes a big difference" and another, "The carers here are more like friends".

People described the staff as being very patient with people who were anxious or shouting. One said, "The staff are so patient and reassuring - I saw [one person] calm down".

All relatives were positive about the care their relatives received. Relatives said, "Mum is treated very well"; "It's been good from day one – the girls are very nice and obliging" and another, "The care is of an exceptionally good standard – I'm glad mum came here".

We observed staff were cheerful and friendly with people and their relatives. We saw them enabling and supporting people and engaging with their relatives throughout inspection.

Staff were proactive in ensuring that people felt accepted for who they were, building a culture of tolerance and acceptance among people. People were encouraged to be in control of their care and where they could not give feedback, every effort was made by staff to understand what they would have wanted. This meant working closely with their relatives and friends. A comprehensive initial overarching social and care needs history was compiled. It included their basic life history, social profile and likes and dislikes. It was then 'tweaked' to them personally and highly personalised as staff got to the know the person and/or their relatives.

A staff member said, "We celebrate all cultures and people. As a staff team we are very open and accepting of each other; sexuality, culture, faith or no faith. This is the same for people; we take people as they are today with no judgement."

People were very positive about the atmosphere at Seymour Court. People commented, "It's warm and friendly without being over familiar"; "It's like Home from Home here and not at all clinical" and another, "I love it here it's like living in a hotel". Relatives were also complimentary about the atmosphere at the home. One said, "It's like one big family here – everyone is looked after – the residents, the families and the staff" and another said, "The atmosphere is friendly and everyone is made welcome".

The provider's website stated, "We promise that everyone who comes to live in our homes will be treated with respect and dignity according to their individual wishes and needs, and we make every effort to provide each person with the care and support they need in line with their assessed needs and feelings."

Several people and relatives mentioned that the managers were approachable and helpful. One person said, "The manager is very good – she often pops in for a chat" and a relative said, "The manager does an exceptional job".

People told us about their privacy and dignity being respected. One said, "They always check with me first before helping me get dressed" and another said, "Staff always knock on the door before coming in to see me which I like".

There were a number of double rooms. Privacy screens were in place and used by staff and visiting health professionals. The registered manager advised how carefully people were matched together so they complimented each other. Also, people were told only a shared room was available on application. Every effort was made to move them to a single room if that was their wish. At end of life, people were supported when they lost their roommate and possibly relocated until after the person passed away.

People and relatives told us they were made to feel special because staff were so attentive and knew about them and their interests. One person said, "They know I like to knit so they bring me in wool" and another said, "When the lady next door was dying, staff sat with her and read to her and when she passed they picked a rose from the garden for her". A relative said, "On my wife's birthday they set up a table in the dining room for lunch for us with a bottle of wine" and another, said their mum had a little holiday with her and when she came back, "Mum was welcomed with hugs as was I and, mum's room had been newly decorated which was a wonderful surprise".

Following the inspection, the provider has highlighted other areas of meeting people's needs. This has included people in life being supported to fulfil wishes before they died. This including seeking cherryade for one person and, supporting another to visit a family grave and drink cider with their friends.

People and relatives said staff made visitors very welcome. One person said, "All the people who visit me have said how friendly the staff are". A relative said, "I visit twice a day and have the code so I can come in when I want" and another relative said, "I am in everyday and am always made to feel welcome and offered a cup of tea".

A staff member said, "We liked to build a good relationship with people's relatives" and another, "We always introduce ourselves to new families; we have a good relationship with most relatives."

Staff spoke of how much they loved their work and the people they cared for. They reflected how the same ethos of what 'good care' should be was reflected in how the registered manager and provider treated and spoke with them. Reflective practice by staff looked at the impact on their and people's moods when something untoward happened. This was with the aim to ensure they were alert to any emotional and psychological outcomes for people and themselves.

Staff said, "I love it; residents, atmosphere, opportunities. We have a good, supportive team"; "We are all here for our residents; some don't have family and we are their family. It is good to come to work" and, "We are a happy, family home."

Good

Is the service responsive?

Our findings

Seymour Court had made a conscious shift to specialise in end of life care. This, they felt, was to fill a gap in end of life care in the area. Close links had been forged with the local acute hospital and hospice. The service was in transition from offering general residential and nursing care to predominately offering end of life care.

The PIR stated: "Our focus on end of life was borne from a recognition that our city lacks a dedicated end of life nursing home, and we had an ambition to succeed where others had avoided this gap in the market. The overarching aim, which would both assist in realising these goals, and would be realised in their success, was to raise occupancy - this included the filling of double rooms that has been previously sold as single, again sensitively approaching this task."

Staff reported excellent liaison with the local hospice both in clinical matters and emotional support. During the inspection, seven people were identified as being on the end of life pathway. Their care record remained as before with regular updates. One person became more poorly during the inspection and by day two of the inspection had their care plan addressed to support staff to give personalised care at this time. The person's mouth did not look dry, therefore although they were not drinking someone must have undertaken some oral care. We spoke with the clinical lead about ensuring this was documented as the person was now refusing drinks. The PIR stated, "Since the transition to end of life care, our pace of work has increased dramatically. We work at a pace where medication, care planning, delivery of care, and relationships with the service user and family all have to be developed far more quickly, and as a result are often more intense, but more short-lived than the practices normally within a residential setting."

We identified an issue that all Treatment and Escalation Plans (TEPs) had not been updated to ensure they represented people or their family members with Lasting Power of Attorney. The TEP is a document that details escalation planning and resuscitation decision-making. The TEPs are completed by a doctor (hospital or their GP). For one person, this was resolved by the second day of the inspection with a visit by their GP. Other people's TEPs were being audited to ensure these were accurate and contact made with their GP as desired. This meant people's rights would be respected.

Some staff had been or were being trained by the local hospice. The Six Steps + Programme is a series of workshops developed by the hospice to provide care homes and agencies with a toolkit to provide quality end of life care. The care staff and nurses we spoke with understood their role and responsibilities at this time. They also exhibited and expressed strong values on the importance of people and their families being supported. We spoke with the registered manager about how the training was being extended to all staff regardless of their role. They told us they had not considered training in end of life care for those acting in an auxiliary role, but would look at ways to involve all staff. This would ensure that all staff understood their role and how to support people at their end of life.

A staff member said, "A person who had no family passed away; I sat and spoke with them and held their

hand; people do not pass away on their own here."

The registered manager told how people were being supported to identify in life, what they would like to achieve before they died. We spoke with the activity co-ordinator who was passionate about ensuring activity was something that involved all living at the service; including those at the end of the life. This was so people experienced touch and knowing someone was there. They also used relevant conversations and information from the person's personal history to highlight for them important people and times that person had had in life. Every person had regular visits on a one to one basis with the co-ordinator, with those well enough to have trips out. The PIR stated, "The Registered Manager and the activities co-ordinator recognised
that often in a residential setting activity focuses on entertainment, stimulation and boredom relief, whereas in an end of life setting activities often revolve around a preoccupation with fulfilling final wishes, with a focus on closure and legacy."

During the inspection we spoke with a family whose loved one had passed away the day before the inspection started. They were welcomed by a name and given a hug when they visited. They told us, "Her end of life was very good; ever so good. They gave mum a wash at night, speaking to her the entire time. They put a clean nightie on her then gave her a kiss. We are content and couldn't have asked for more. She was safe and in good hands." They added that they were supported to stay in the family room and called them in time so all the family could say goodbye. Also, the staff were present discreetly and administered medicines to ensure the person had a pain free death, but did not intrude in the family's time. After the person died, the support was in place not to rush the family and make sure they were alright.

People had personalised care plans in place. People using the service were allocated a key worker. People and their relatives told us they were involved. One person said, "I know what's happening and it does happen" and another said, "We talk about this from time to time and my daughter also gets to see it". One relative said, "Mum's care plan is discussed with us" and another said, "This is reviewed regularly and we get to look at it and give our views".

Staff told us the care plans were up to date and they were active in contributing updates that ensured they reflected the most current care needs for people. People's personal history was sought to ensure people's wishes, feelings and likes and dislikes were actively represented in the written word and in staff practice. People living with dementia and/diabetes had plans that told staff how those conditions were affecting people now, that were different for each person. General information was also included for staff to look out for so they could be alert to any changes in people's presentation.

Staff spoke about efforts they made to communicate with people and understand those who struggled to speak, see or hear. However, we did identify that the care plan of a person living with Parkinson's could improve to cover more detail on how the person and staff communicate. This was also relevant for people who had sight and auditory issues. This would ensure they were fully compliant with the Accessible Information Standards. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Following the inspection, the provider advised us two people unable to communicate verbally had picture bards in their bedrooms. They pointed to the pictures to indicate what they would like and the pictures have a cross and a tick to indicate yes or no answers. Also, a person registered blind has stickers in different shapes on items to distinguish between different objects. They have a talking clock and tapes which are

used on a regular basis. Also, the call bell is raised star on it in the area to press if she needs to call for help.

People were encouraged to feel secure in their own identity regardless of their sexuality, faith, culture and ability. People were then responded to positively in how they wanted their identity described in their care plans and met. For example, one person was empowered to attend the local Pride festival. The provider's website stated, "We are committed to valuing each and every individual that lives in our care homes and welcome residents from all walks of life with many different needs, who enjoy the opportunity to share and celebrate the richness and diversity of their experiences."

People had their faith needs met. People at the service led their own multi-denominational religious service, People liaised with a local church who supports them twice a month to deliver a service for those who wish to attend. People were also assured to have their faith needs met at the end of life.

The provider advised they hold a Summer Fete and celebrations of Christmas, Easter and, important anniversary events such as Valentine's day, Remembrance Day. They also run person centred activities with trips out. They also said they also are involved with projects with Plymouth University, local schools and the National Marine Aquarium.

People were supported to raise any issues or concerns they had. The complaints policy was available to people and relatives. Complaints were handled very carefully with reflective practice completed often to see what learning could be taken forward. The registered manager advised that complaints were taken very seriously. Even if the original complaint was not upheld, they explored what other factors lay behind it that needed addressing. The PIR stated, "Complaints are always dealt with immediately, and investigated fully, with feedback given at the end of every complaint. The Registered Manager uses reflective practice to establish what was done well, and what can be improved upon by both team and management. The Registered Manager and Clinical Lead recognise, acknowledge and act on the assumption that even is a complaint that is raised is unfounded, there will be some element of discontent or grievance to initiate this complaint, and often, sourcing this origin of grievance is the key to effectively managing the complaint."

One person said, "I talk to the manager about things that concern me" and another said, "I've never had to complain but would talk to the manager if I needed to". A relative said, "The manager's door is always open and I know absolutely that issues will be resolved". Another relative told me that they knew about the complaints process adding, "This hasn't been necessary but I'm confident I could talk to the manager and it would be dealt with to my satisfaction".

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well-led.

The registered manager and provider had extensive quality assurance processes in place. These reviewed aspects of the care given. For example, care plans were reviewed and action taken to ensure there were no gaps. Also, there were spot checks and audits by the area manager, registered manager and clinical lead. However, the issues in respect of the outside of the building and medicines had not been identified and acted on.

We found the provider, registered manager and area manager to be very responsive to, and accepting of the concerns when they were highlighted, with action being taken immediately to address these issues.

Seymour Court, under the previous provider, had spent time in administration. The registered manager and staff spoke with us about how this had brought them together. Many of the staff had stayed and spoke of the positive influence of the new providers. Staff felt they had been looked after well during this time and now welcomed the financial stability that meant they could deliver better care.

A registered manager was employed to oversee the service locally. 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. They were supported in this role by a clinical lead and two care managers.

People, relatives and professionals all spoke highly of the service and how it was run. Comments from people included, "The managers and staff are magic - real stars"; "I can't speak highly enough about the manager" and another said, "It's well led from the top here".

Relatives said, "The manager has her finger on the pulse"; "It's absolutely well led"; "This place is special - everyone cares here for both me and my wife and that comes down from the managers"; "The team here works well together led from the top – the caring ethos comes down from the owner and the managers" and another said, "Everyone goes an extra mile here".

The registered manager and provider's philosophy of care were evident in their passion for meeting people's needs. The provider's website stated, "We will ensure that anyone who comes to live with us will be at the heart of everything we do. We strive to enhance people's quality of life, by providing an excellent standard of support, which embraces our person-centred care framework." The registered manager told us, for example that they worked on the floor as they were needed and would step in to meet any task that needed doing. The provider and registered manager also respected the service had been in transition for the past year and remained so; they were actively supporting people, relatives and staff through this process. There were regular meetings to ensure good communication and an 'open door' for all to express how they were feeling.

Visitors (relatives, friends and professionals) were encouraged to give instant feedback each day so positive and negative comments could be captured. These were written on sticky notes on that days 'thought of the day' sheet placed in reception. These were acted on and shared with staff to keep any reflection live. This meant staff were getting instant positive feedback and putting right any issues.

Staff said, "Any problems I can speak to [the registered manager] or [clinical leads]. They are very approachable. They are also interested in me and my family; everyone is so caring"; "[The provider] is very nice; we are all one big happy family. They have taken us through [the changes]; all lovely"; "Management are very supportive; we can go to [the registered manager] about anything; personal issues are kept as such. The nurses are really good for support too" and, "The registered manager's support is very good. I can raise any concerns or questions and they are always sorted or answered."

The registered manager attended the local Dignity in Care Forum and registered manager sessions organised by the local authority. Everyone strove to keep themselves up to date and ensure they received updates from a range of sources. Professionals linked with the service were very positive about the links with them, describing their involvement as appropriate, timely and as partners.

There was a system of maintenance and ensuring statutory checks of fire equipment, for example were in place.

The registered manager and provider had introduced a policy in respect of the Duty of Candour (DoC) and understood their responsibilities. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct. Staff told us they felt confident concerns raised with the registered manager would be addressed appropriately.

CQC had received all notifications as required. Notifications are events that registered people are required to tell us about by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b)(g) Aspects of proper and safe management of medicines were not met. Risks in respect of the premises had not always been assessed and all steps therefore taken to keep people safe.