The Orders Of St. John Care Trust

OSJCT Seymour House

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

Summary of findings

Overall summary

OSJCT Seymour House provides accommodation and personal care for up to 42 older people some of who are living with dementia. At the time of our inspection there were 42 people living at the Home.

The inspection took place on the 7 and 8 September 2016. The first day of the inspection was unannounced.

The service had a registered manager in post at the home. 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 the last comprehensive inspection in July 2015 we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because necessary records of assessments of capacity and best interest decisions were not in place for people who lacked capacity to decide on the care provided to them by the service. The service had not made all necessary applications to the local authority for Deprivation of Liberty Safeguards authorisations to protect people from being deprived of their liberty without lawful authority. The service did not always provide care in a safe way by taking all reasonably practicable measures to mitigate risks.

At this inspection we found the provider had taken action to address the issues highlighted in the action plan. There was evidence people consented to their care and treatment at OSJCT Seymour House and where people lacked capacity to consent, the necessary mental capacity assessments and best interest decisions were completed. Where needed deprivation of liberty safeguards applications had been made to the local authority. The service had taken actions to reduce risks where people had more complex needs, for example implementing food and fluid charts, making referrals to health colleagues and introducing assistive technology.

People's medicines were not consistently managed safely. This was due to a new system in place which increased the risk of medicines errors occurring. The registered manager was aware of the concerns and was reviewing the new administering system. They had already been in discussions with the Order of St. John's Trust before our inspection.

People and relatives spoke positively about the care and support they received. Staff showed concern for people's well-being in a caring and considerate way, and they responded to their needs quickly.

People were treated with dignity and their right to privacy was respected. Staff knocked on people's doors before entering and sought people's permission before undertaking any care tasks. We found staff had a good understanding of people's needs, interests, likes and dislikes. We observed a range of positive and caring interactions during our inspection, with people using the service not hesitating to seek assistance where required and sharing jokes with staff.

People spoke positively about the food choices and were supported to have sufficient food and fluids. People were offered a choice at meal times and where people did not want what was on the menu alternatives were available. There were plenty of drinks and snacks available during the day and night.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required.

There were systems in place which encouraged people and their relatives to share their views on the service. Complaints were investigated and responded to appropriately. People told us they were regularly consulted about their care and they attended six monthly care review meetings.

Risk assessments were in place to support people to be as independent as possible. Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Staff displayed a good understanding of how to keep people safe from potential harm or abuse and what actions they would take should they suspect abuse had taken place. There were enough staff on duty to meet people's care and support needs safely.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. The staff had received appropriate training and supervision to develop the skills and knowledge needed to provide people with the necessary care and support. Training was regularly updated, with staff attending a range of core training such as infection control and safeguarding, as well as training specific to the needs of people using the service, for example dementia awareness.

The provider had quality monitoring systems in place. Accidents and incidents were investigated and discussed with staff to minimise the risks or reoccurrence. The management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

The building was easily accessible for people living with dementia as well as people with a visual impairment. There were coloured walls, pictorial signage on bathroom and toilet areas and clearly named room doors to help people find their way around independently.

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

This service was safe.

A new system for the management and administering of medicines had been introduced, which increased the risk of medicines errors. The management team were aware of the concerns and had been addressing them.

People told us that the home was a safe place to live because they felt secure in the building. They also told us their belongings were safe.

People's personal safety had been assessed and plans were in place to minimise these risks.

Safe recruitment practices were followed before staff were employed to work with people. There were sufficient staff to meet people's care needs.

Is the service effective?

Good

This service was effective.

Staff received the necessary training and had the right skills to meet people's needs. Training records confirmed staff received training on a range of subjects.

Staff were aware of people's dietary needs. People told us they liked the food and were able to make choices about what they had to eat.

People's care records showed relevant health and social care professionals were involved with people's care.

Is the service caring?

Good

This service was caring.

People and their relatives spoke positively about the care and support provided. People's dignity and privacy were respected by staff.

People's bedrooms were personalised and contained people's personal belongings. People were able to choose where they wished to spend their time.

Staff showed concern for people's wellbeing and responded to their request for support promptly.

Is the service responsive?

Good

This service was responsive.

'Resident and relative's' meetings were held quarterly and gave people the opportunity to express their views about the service.

Care and support plans were personalised and were reviewed regularly.

People were supported to take part in social activities and to follow their interests.

Is the service well-led?

Good

This service was well-led.

Quality assurance systems were in place to monitor the care and support that people received and where required identify improvements.

Staff felt supported by the registered manager and could raise concerns and seek guidance.

Staff were very passionate about providing a good service to people and understood the values of the service.

OSJCT Seymour House

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.

We carried out this inspection over two days on the 7 and 8 September 2016. The first day of the inspection was unannounced. One inspector and an expert by experience carried out this inspection on the 7 September and one inspector returned to complete the inspection on the 8 September 2016. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last comprehensive inspection in July 2015 we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the 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. The provider had returned the PIR in June 2016.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 12 people who use the service and two visiting relatives about their views on the quality of the care and support being provided.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included six care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the manager, three care staff, housekeeping staff and staff from the catering department. We received feedback from one health and social care professional who worked alongside the service.

Good

Is the service safe?

Our findings

At the last comprehensive inspection in July 2015 we identified that the service was not meeting Regulation 12 (1) (2) (b) of the Health and Social Care Act (2008) Regulations 2014. This was because the service did not always provide care in a safe way by taking all reasonable practicable measures to mitigate risks. It was noted that for people who had more complex needs there were some areas where measures to reduce risks had not been taken. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found the service maintained the measures they had put in place to ensure people received their care in a safe way. Risks to people's safety had been assessed and plans were in place to minimise these risks. This included risks in relation to falls, malnutrition and developing pressure ulceration. There was clear information in people's care plans which provided staff with guidance on how to reduce these risks. For example, when someone had a fall, a sensor mat was put in place with the person's consent as well as a falls prevention care plan. These risks were regularly reviewed and changes updated as required. Where people were prone to infections such as urinary tract and chest infections, we saw evidence of acute care plans, which stated when their treatment started, previous infection dates, if the person was seen by the GP as well as when the treatment was due to stop. This helped the service to monitor the risks to people's health and to take action when needed.

People and their relatives told us they or their family member felt safe living in a secure home and also felt their belongings were kept safe. Comments from people included: "I feel very safe. I was going to move to another home nearer to where I used to live. I came here and felt so settled that I didn't want to move", "Everything is very safe. I know that my things will be safe.", "Safe because everybody looks after you if you become ill. They come in the morning to get you up and dressed. Very nice here", "Safe because I know that I can talk to anyone if I have any worries," and "I know that people will listen and you can get people to sort things out".

Speaking with relatives they said "X is safe here. When they got to the point of needing hoisting their room wasn't big enough so they moved them to a large double room where they could be moved around safely. A superb room freshly decorated and carpeted" and "[Person] says they feel safe and that it feels like their home".

The system used for the management and administering of medicines was not consistently safe. We observed the lunchtime medicines round and saw the medicines trolley lock was broken. The staff member administering the medicines told us this had been reported to the registered manager and they were awaiting a replacement. However we found safety measures had not been put in place in the short term and the trolley was left unattended during the medicines round. A medicines error was reported during the medicines round where a staff member found some tablets on the floor of a person's bedroom. We saw appropriate action was taken to report this to the registered manager who was investigating this further. The tablets were disposed of safely and we were told the pharmacy had been contacted for advice. The new system used for the management and administering of medicines increased the risk of medicine errors

occurring. This was because all medicines were delivered in its original packaging and staff had to count out medicines for people as prescribed. This meant that medicines prescribed for a specific time and specific dose could easily be missed on the MAR (medicines administration records) charts. The registered manager was fully aware before we raised our concerns and showed us correspondence with senior management in the Trust, detailing their concerns and requesting to return to the old system of using blister packs.

We observed medicines being administered in a respectful way. The staff member stayed with the person to ensure they had swallowed their medicines and drinks safely. People were asked how they wanted to take their medicines, for example in their hand, a spoon or in a cup. Where people were not ready to take their medicine the staff member respected this and returned when they were ready. Where people refused their medicines this was respected. It was recorded on their MAR and where required medical advice was sought.

The administration of medicines was restricted to those staff who had received training in the safe administering of medicines. Records showed staff had received training on safe medicines management. There were records to demonstrate that checks had been undertaken to ensure they were competent to administer people's medicines.

People were kept safe by staff that recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised. Clear policies and procedures were in place to inform staff of the processes they needed to follow should they suspect abuse had taken place. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this. A staff member said: "I've not had to report any abuse but know which signs to look out for, for example bruises or scratches. Or it could be emotional abuse where people could be withdrawn or quieter than normal".

Staff said they would report abuse if they were concerned and were confident the manager would act on their concerns. Staff were aware of the option to take their concerns to agencies outside of the service if they felt actions to deal with their concerns were not being taken. The manager was clear about when to report concerns and the processes to be followed to inform the local authority, police and CQC. Staff also told us they felt confident to report any concerns regarding poor practice from another member of staff.

There were sufficient numbers of suitably qualified staff to keep people safe and meet their needs. We spoke with the registered manager who explained how they used a dependency tool to ensure appropriate staff were deployed at all times. We saw staffing rotas reflected the staffing levels identified by the dependency tool. At all times during the inspection we observed adequate numbers of staff on duty which meant people received the required care and support. One person said "Generally enough staff but weekends not so good at times. Seems short staffed then. They [staff] often tell X[person] that they are short staffed, shouldn't really be telling residents this." Most people told us that there were enough carers around to support them during the day and the night.
Call bells were answered swiftly and staff took time to speak with people. We observed that one resident was constantly unplugging their call bell which triggered an automatic alarm. Staff attended on all occasions and made no attempt to remove the device.

We saw safe recruitment and selection processes were in place. We looked at the files for four of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. The registered manager told us that the provider had introduced a new online application system and recruitment tracker to ensure safe

recruitment and selection of suitable staff. People and relatives were asked to be involved in the interviewing process. The registered manager told us there had been an occasion where they didn't recruit a carer due to feedback from people using the service.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Where people had fallen, we saw action had been taken, for example a referral to an occupational therapist, eye appointment to check eye sight and a referral to the falls clinic. Falls monitoring sheets were completed to check for developing trends. The registered manager told us that they noticed people were falling more during the evening when people were getting ready for bed. This was addressed and where it was identified that people were at risk of falling, preventative measures were put in place, for example sensor mats to alert staff when people got up from their chair or out of bed.

The service had appropriate arrangements in place for managing emergencies which included fire procedures. There was a contingency plan which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. The night care staff also had opportunities to take part in fire drills.

Good

Is the service effective?

Our findings

At the last comprehensive inspection in July 2015 we identified that the service was not meeting Regulation 13 (1) (5) of the Health and Social Care Act (2008) Regulations 2014. This was because we found that the service had not made the necessary applications to the local authority for DoLS authorisations to protect people from being unlawfully deprived of their liberty. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection. At this inspection we found that action had been taken and where required, the necessary applications had been made, though people were still awaiting an assessment to authorise the applications.

At the last comprehensive inspection in July 2015 we identified that the service was not meeting Regulation 11(1) (2) (3) of the Health and Social Care Act (2008) Regulations 2014. This was because when people lacked capacity to decide on their care, the provider did not have assessments of capacity and best interest decisions in place to underpin the care plans for these people. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found action had been taken and where people lacked capacity to make decisions about their care. Mental capacity assessments had been completed and best interest decisions recorded. For example, we saw best interest discussions and decisions around monitoring equipment and people leaving the home unescorted had been recorded.

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 legally authorised under the MCA. People can only be deprived of their liberty to 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 are called the Deprivation of Liberty Safeguards (DoLS).

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. We saw that where staff had concerns about people not eating or drinking sufficiently, the GP had been contacted and staff commenced food and fluid charts to monitor their intake. There were records of treatments relating to chiropody, eye care and district nurse visits in people's records. A GP visited the home on a weekly basis and more frequently as requested by staff in response to people's medical needs.

People told us they liked the food and were able to make choices about what they had to eat. Comments included: "Food is smashing, everything good. If you say that you are not keen they ask what you would like instead", "We had chicken yesterday, very nice. Love thick soup to start, excellent", "Food quite good. I'm not a fussy eater so I eat everything on offer - good quality." "Food is nice. I specify a small portion, because I

don't eat as much these days, and that's what they give me" and "Food is very good here, tasty, you can have more if you want it." We saw a person changed their mind when shown the two meals of the day. An alternative was provided within minutes.

Snacks and drinks were available throughout the day and night, including fruit, crisps, biscuits and chocolate bars. Different flavoured juice machines were available at various locations around Seymour House. We also saw there were kitchenettes on the lower and top floor for people to use for making hot drinks or toast if they wished to do so. Relatives were also able to make use of these facilities when they visited.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included "X is diabetic. They take blood sugar levels three times a day and know how to care for someone with this condition." and "They do many days of training for this job. Well trained here".

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. New members were supported to complete an induction programme when they started working at the home and were able to shadow more experienced members of staff before working independently. There was a training matrix in place which recorded the training staff had completed and staff said they were supported to refresh their training as required. Training undertaken by staff included safeguarding of vulnerable adults, fire safety, infection control and moving & handling. All staff who had been in post over six months were given the opportunity to complete the Qualifications and Credit Framework (QCF) in Health and social care.

Staff told us they received regular supervisions (one-to-one meetings) and annual appraisals which supported them in their role. There was a matrix in place which detailed when staff had received their supervision. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had.

The building was easily accessible for people living with dementia. There were coloured walls, pictorial signage on bathroom and toilet areas and clearly named room doors to help people find their way around independently. Coloured toilet seats and rails in the bathroom also promoted people's independence. In addition, natural daylight and good artificial lighting supported people living with a visual impairment. Hand rails down the corridors enabled people with limited mobility to move independently around the building.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included: "Staff are very good, generally very kind and will get you what you want", "Care is perfect. All lovely, they really are. You tell them if you don't like anything and they listen.", "No worries here. They always look after you and take care of you", "Most staff very caring on the whole." and "Carers who look after me are very good. Have a bit of a laugh with them. A sense of humour is very important." One person said "Girls very good, just occasionally somebody gets cross".

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. A relative told us "Carers are good because they know people and know how to take care of them".
We observed that staff were careful to ensure peoples' dignity was maintained and saw they listened to what people wanted and supported them in their decisions. Peoples' privacy and space was respected. We saw staff knocking on residents' doors waiting to be invited in, and closing doors behind them. We heard staff referring to relatives and residents by name and speaking to them in a respectful way, which ranged from light-hearted banter to more serious conversations. Staff told us the Trust was piloting night staff wearing their pyjamas whilst working the night shift. There had been a positive effect with people who were living with dementia.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews and annual surveys. People were also invited to residents' meetings which were an opportunity for people to talk about things that mattered to them.

People's care was not rushed enabling staff to spend quality time with them. We observed staff sitting down with people, talking to them about things that interested them. Staff supported people who found it difficult to make their own decisions. People were given the opportunity to communicate their wishes, sometimes in a non-verbal way. For example, staff spent time with people finding out which choice of meal they would like. Where people were unsure what the choices were or unable to understand the choice, staff used pictorial menus or showed people plates of food to support their decision making. The registered manager told us they also wanted to introduce "butterfly" moments, which would allow staff who had five minutes free to spend it with people and for example, paint nails or read the paper with them.

People living with Dementia were given time to respond to questions and their wishes were respected. For example a person living with dementia was coming into the dining room and saw someone was sitting in their usual seat. They seemed worried and was about to walk away when two carers reassured her that the person was moving. They gave her choices, 'Would you like dinner in your room or in a quiet lounge'. The person replied they would like to sit at their usual table with their friends. Another person said "They tell me what they are going to do before they do it. Very important to me because I am partially blind."

The home was spacious and allowed people to spend time on their own if they wished. There were different

lounges and seating areas where people could go and we saw some people had their favourite seat they liked to sit. People had access to a large garden with seating areas. The garden area had level pathways and was designed to allow people to move freely and safely around it. During our inspection we saw people were able to go out in the garden, for example when they wanted to smoke or just for some fresh air.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. We saw people moving around the home freely and some people had their own jobs around the home. For example one person was responsible for feeding the fish, another was looking after the house cat and another person helped with laying the tables in the dining room.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. One staff member told us about a person who enjoyed a glass of Baileys in the evening. However due to the person's memory loss, they continued to consume the whole bottle as they had forgotten they already had some. The staff member arranged a meeting with the person and their family to resolve the situation and all came to the decision to store the bottle in the kitchen. This enabled the person to continue having their favourite drink, which they had always previously enjoyed, and also promoted their health and well-being.

Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. Staff told us that they knew people's routines and for one person particularly, they knew the person became anxious when their routine was not followed. For example, staff had to support the person to dress in a particular way. Staff knew if they did not follow the routine, the person's emotional well-being would be affected for the rest of the day. For another person they knew as soon as the person's juice cup was empty, the person liked it filled up straight away.

People and their relatives were given support when making decisions about their preferences for end of life care. An end of life care pathway was followed, which included completing an end of life care plan. People who were on end of life care received little treat bags, which included lip balm and hand cream. Staff would sit down with people if they wished and massaged their hands and feet. Relatives were given the choice to stay at the Home when people were nearing end of life. The registered manager put together small overnight bags for relatives, including shower gel and a toothbrush.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Plans had details of people's likes, dislikes and preferences. These included how often and when they wanted support with personal care, and their bedtime and morning routines.

People and relatives told us they were also involved in the on-going review of their care needs. People said "We talk about my care plan but not really necessary. They know all about me so I just let them get on with it." and "Carers know what I need. If not happy with anything I tell them". Relatives we spoke with said "I have regular care reviews with the carers and Mum" and "I come to review meetings about every 6 months."

Care plans included information that enabled the staff to monitor the well-being of the person. Where a person's health had changed it was evident staff worked with other professionals, for example people who had swallowing difficulties were referred to a speech and language therapist. We saw that where recommendations were made by the professional, for example a pureed diet, that staff were aware and followed the recommendations.

People told us they had a keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and spending time with them. This meant that staff got to know people well and could identify any change in their health and well-being and act on it immediately.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. The registered manager told us they had introduced care leaders, who were responsible at the beginning of each shift for checking people had their call bells within reach, had a drink, their commode was clean and their bed tidy. The care leader was also responsible for ensuring staff took their breaks when necessary and that daily records were kept up to date.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. People told us there was enough to do at Seymour House. Comments included: "Trips are very good, lots of things to do.", "They [activity staff] bring round the booklet with what is happening. I enjoy the Bingo, exercising with the beach ball and cake-making" and "Plenty going on to keep your mind and body going." Activities were organised by two activity staff across five days a week and on alternate weekends. Activities included flower arranging, cake making, painting, Bingo, gardening, nails and natter, word games and reminiscence activities. A visiting exercise specialist and musicians also supported the programme of activities. A programme of one to one activities ensured that people who were unable to leave their rooms or who preferred not to participate in group activities had the opportunity to follow their particular interests.

The activity programme related to peoples' interests and impacted on their quality of life. For example, as part of the make a wish programme, activity staff arranged for a resident, with a particular interest in cars, and his friend to be taken to a local racing circuit where they were taken round the circuit in a sports car. Staff told us that the excitement prior and post the event had made a real difference to the people concerned. On another occasion a member of the activity staff noticed that a resident was looking unhappy. When asked why, he said that a folk festival was happening in the town, which he always used to attend. A staff member responded straight away and took him and some friends to the festival. A group of Morris dancers who were at the festival, came back to Seymour House afterwards and gave a performance for all the other residents. People were also supported to attend other events of interest to them, for example a fruit and vegetable show arranged by the Trust, where some people from Seymour House entered and won prizes. One person in particular told us they were very proud of winning a rosette for their entry.

People's concerns and complaints were encouraged, investigated and responded to in good time. People told us that the service was open and responsive to complaints but most people went on to say that they had never complained. The complaints procedure was clearly displayed in the entrance hall and people told us that they knew how to complain. We saw evidence where complaints had been raised, for example dissatisfaction with how the laundry was managed, that the registered manager responded in a timely way and communicated any outcome to staff and people involved. Where needed apologies were made.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who was responsible for the day to day running of the service. The registered manager was supported by an area manager who was present during our two day inspection. The area manager was in regular contact with the registered manager. The registered manager had a strong vision of providing person centred care to people and to continuing improvement. The registered manager said "This is the people's home. We are visitors in their home". The registered manager was keen on peoples' input in everything they did in the Home and was planning on involving people in staff training. People already had the opportunity to sit in during training, but the registered manager wanted to use people's expertise as well.

The registered manager was also committed to their own professional development to ensure best practice. They told us they had recently completed a 3 year My Home Life Development Programme, which is an initiative promoting quality of life and delivering positive change in care homes for older people. They had also applied to complete a QCF (Qualifications and Credit Framework) Level 2 in Dementia care. The registered manager was keen to improve their dementia care further, for example creating some "feely" boxes to put around the home. These boxes would have various items for people to touch, which had been found to be very beneficial in dementia care. The service also worked closely with the Admiral nurse, who provided advice and training around dementia care. The registered manager followed a dementia fifty point checklist to look at things they already did well and also what else could be done to enhance the lives of people living with dementia. Staff told us the registered manager had turned the home around since being in post and they had definitely seen an improvement.

There was an open transparent culture in the home; people were kept informed, included in decision making and felt confident to raise concerns or make comments. We saw evidence that residents and relatives meetings took place. The registered manager told us a relatives meeting was due to take place later on the day of our inspection. We saw an agenda covering subjects such as menu and meals, recruitment, activities, friendliness of the home, six month reviews and what the home was doing well and what could be improved. Feedback from a relative stated "We are kept up to date with everything. I can't think of anything that could be improved". We saw evidence that change had occurred from suggestions at a residents' meeting, for example people said they wanted table cloths back on the tables, which was responded to.

Staff comments showed that they were well-motivated and felt supported by the registered manager. Regular staff meetings were held to make sure staff were kept up to date and given the opportunity to raise any issues that may be of a concern to them. The registered manager told us all staff meetings were opened with a thank you. It was important to the registered manager to show appreciation to staff for the work they did. The registered manager regularly brought in biscuits and chocolates for staff to have. All staff spoken with provided positive feedback about the registered manager and the support they received. Comments included "[Manager] is one of the most transparent people I know. She nurtures staff really well", "I can talk to the manager about anything. She is lovely" and "Concerns are acted on immediately. [Manager] is very good". The registered manager also made sure useful information was on display for staff to read. There was

a notice board with numerous articles and up to date research about dementia on display for staff and others to read.

People told us that they knew the registered manager well and that she was approachable and always about. Comments included: "Can always go and chat to the manager if there is a problem" and "I see the manager about, say hello most days". We saw people entering the registered manager's office during our inspection to have a conversation or just ask a question. People were welcomed into the registered manager's office. People were involved in creating a monthly newsletter with articles and photos of any events or other activities of importance to them.

Internal audits undertaken, for example falls, call bells and infection control audits, had identified shortfalls and action had been taken. We saw the infection control audit identified that commodes were not cleaned and stored correctly. Actions were put in place on the same day of the audit and it was communicated to all staff. Staff were encouraged to take on specific areas of responsibility, for example in medicines training, falls, dementia and infection control.

Other systems for ensuring best practice came from the provider organisation; The Order of St John Care Trust (the Trust). Unannounced audits were completed by the Trust, for example catering audits where food was tasted. The Trust also shared information of incidents or best practice from other homes with the registered manager. The registered manager told us they had regular contact with managers from other OSJCT homes and could share concerns or ideas. The registered manager had been in contact with the Trust about the concerns they had about the safety of the new medicines management system and this was in the process of being reviewed.

The registered manager told us the Trust also rewarded staff for their service, for example a staff member had been working for the Trust for 30 years. They received a long service award and a gardening voucher.

The service had made links with the local surgery, shops, churches and volunteers. The registered manager told us they had received donations from various local shops, for example when people wanted to create a mosaic. The registered manager contacted a local DIY shop who was happy to donate the materials for the mosaic. The mosaic is now visible in the garden for everyone to see. Local supermarkets supported the home, for example one delivered flowers once a week and another held a coffee morning where people from local homes were invited to. Seymour House encouraged volunteers who maintained and supported people with gardening activities. A local student had been coming in every weekend for two years to support the activity programme, before going off to university this academic year and pupils from a nearby school came in one day a week for six weeks as part of their social awareness programme. As part of their Duke of Edinburgh award, pupils came in to work alongside care staff, chatting to people and supporting the activities. In addition the wider community was invited in for special events such as fetes and barbeques.