The Community of St Antony & St Elias

The Community of St Antony & St Elias - 2 Seymour Terrace

Inspection report

2 Seymour Terrace
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 14 and 16 February 2018. 2 Seymour Terrace was previously inspected in August 2015 and was found to be meeting the regulations inspected at that time.

2 Seymour Terrace is a small care home that provides accommodation, personal care and support to a maximum of four people of working age who are experiencing severe and enduring mental health conditions. 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. At the time of the inspection there were four people living at the home.

There was a registered manager in post at the time the inspection they were also overseeing another home owned by the same provider. An interim manager had recently been appointed by the provider to oversee the home in the registered managers' absence and is referred to throughout the report as the house manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The home's quality assurance and governance systems were not always effective. Although some systems were working well others had not identified the concerns we found during this inspection.

Risks to people's health and wellbeing were not always managed safely and the systems in place to minimise risks to people's health and safety were not always understood by staff. For example, where guidance had been provided to reduce the risk posed by people smoking, it was not always known to staff or followed. This potentially placed people at increased risk of harm.

People did not have personal emergency evacuation plans (PEEP) in place. The purpose of a PEEP is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. This meant staff did not have all the key information they needed to assist people to leave the building in the case of an emergency. Records showed that routine checks on fire equipment and premises safety were being completed

People's rights were not always protected. Records for one person showed there were various restrictions in place, which prevented this person from leaving the home when they wished to do so. Records showed these restrictions were discussed with external professionals every three months as part of this person's formal discharge arrangements. We found there was no legal basis or framework in place to support these restrictions.

We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA). We

found the home was not taking appropriate action to protect people's rights. For example, where the home held or managed people's monies and/or bankcards, there were no mental capacity assessments to show that people did not have capacity to manage their own finances. There were no records to show the rationale for these decisions, or whether this was being carried out in their best interests.

We looked at the care records for people living at the home and found some people's records were not written in a person centred way, contained outdated/ misleading terminology and did not always provide staff with sufficient detail to support the person's needs. For example, people's records contain references to 'unescorted leave'. This would imply that there were times when people living at the home were not able to go out without some level of supervision or were restricted in some way. We discussed this with the registered manager who assured this was not the case.

People told us there was enough staff to meet their needs and keep them safe. We saw staff had time to spend with people on a one to one basis and support them to attend appointments, go shopping and socialise.

We have however made a recommendation that the provider uses a suitable tool to determine people's level of dependency to ensure that staffing levels are sufficient to meet people's assessed needs. There was no tool in place and staff told us the 'Community' had been slow to recognise the need for extra staffing when people's support needs had increased.

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People's support plans included details of their appointments and staff we spoke with knew people well. People received their medicines when they needed them and in a safe way. People were cared for and supported by staff who knew them well. Staff were kind, caring and treated people with dignity and respect. The registered manager and staff understood their roles and responsibilities to keep people safe from harm and protect people from discrimination.

People told us they had confidence in the staff supporting them and felt staff were well trained. Newly appointed staff undertook an induction programme and there was a comprehensive staff-training programme in place. Staff confirmed they received regular training, supervision and annual appraisals.

People told us they felt they had control over their lives. Staff explained how they empowered people to manage their own needs independently and supported them. People were encouraged to be as independent as possible with the planning, shopping and cooking their own meals. A large kitchen was freely accessible and well stocked with Tea, coffee and soft drinks.

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated. People's support plans contained detailed information about people's hobbies and interests. People had many different opportunities to socialise and take part in activities if they wished to do so.

People were aware of how to make a complaint and felt able to raise concerns if something was not right. People told us they were encouraged to share their views and senior managers regularly carried out unannounced spot checks and audits of the home. These included speaking with people who lived at the home in order seek their views, and auditing all aspects of health and safety.

People, relatives and staff told us the home was well managed, and described the management team as open, honest and approachable. Staff were positive about the support they received and told us they felt

supported and valued by both managers.

The registered manager was aware of their responsibilities in ensuring the Care Quality Commission (CQC) and other agencies were made aware of incidents, which affected the safety and welfare of people supported by the home.

The home was clean, well maintained, and people were protected from the risk of cross contamination and the spread of infection. Staff had access to personal protective equipment (PPE) and received training in infection control

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 home was not always safe.

Risks to people health, safety, and well-being were not being effectively assessed, managed or mitigated.

There were sufficient numbers of skilled and experienced staff to meet people's needs. However, the provider did not have a systematic approach for assessing staffing levels to ensure they could meet the needs of people living at the home.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who lived at the home.

People were protected from the risk of abuse; staff were trained in safeguarding adults and were aware of how to identify and respond to allegations and signs of abuse and how to raise any concerns.

Safe and robust staff recruitment procedures helped to ensure that people received their support from suitable staff.

Is the service effective?

Requires Improvement

The home was not always effective.

People's rights had not been protected. Staff were depriving someone of their liberty without legal authority.

The principles of the Mental Capacity Act 2005 had not been followed in relation to some best interest decisions.

People were cared for by staff who received regular training and supervision, and were knowledgeable about people's needs

People's health care needs were monitored and referrals made when necessary.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The home was caring.

People were positive about the care and support they received and felt staff were kind, caring and treated them with respect.

People's privacy and dignity were respected and their independence was promoted.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

Some aspects of support were not always responsive.

People were at risk of not having their care needs met in a consistent way that respected their wishes and preferences.

People's care plans were personalised with their individual preferences and wishes taken into account.

People were confident that should they have a complaint, it would be listened to and acted upon.

People enjoyed a variety of social activities.

Is the service well-led?

Requires Improvement

The home was not always well led.

Although quality assurance systems were in place, they were not being used effectively or undertaken robustly enough to identify the issues seen during the inspection.

People's care records were not always accurate or kept up to date.

There was an open, transparent culture and staff felt supported by the homes management team.

Competent staff who felt supported and valued supported people.

The home had notified the CQC of incidents at the home as required by law.

The Community of St Antony & St Elias - 2 Seymour Terrace

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

This unannounced comprehensive inspection took place on 14 and 16 February 2018 and was unannounced. The inspection team consisted of one adult social care inspector. The home was previously inspected in August 2015 when it was found to be 'Good' in all areas.

Prior to the inspection, we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also reviewed the information we held about the home. This included previous inspection reports and statutory notifications we had received. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

During the inspection, we met three people and spoke individually with two people living at the home as well as two relatives, four members of staff, the registered manager and Head of Care.

We asked the local authority who commissions the home for their views on the care and support given by the home and received feedback from two healthcare professionals.

To help us assess and understand how people's care needs were being met, we reviewed four people's care records. We looked at the medication administration records and systems for administering people's medicines. We also looked at records relating to the management of the home: these included four staff recruitment files, training records, and systems for monitoring the quality of the services provided.

We used elements of the short observational framework for inspection tool (SOFI) to help us make judgements about people's experiences and how well they were being supported. SOFI is a specific way of observing care to help us understand the experiences people had of the care at the home.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm because the systems in place to manage risk were not always effective and staff did not fully understand how to reduce the risk of harm to people.

Although the registered manager carried out an assessment of each person's needs prior to them moving into the home, some risks were not identified or not managed appropriately. We reviewed people's risk management plans and found one person who smoked, had been identified as being at 'Medium Risk'. Records showed this person had been found smoking in their bedroom on numerous occasions. This person's risk management plan, which had been reviewed in September 2017, provided guidance for staff to follow to reduce the risks associated with smoking. For instance, the person was to hand in all smoking material to staff each night. Staff were guided to be 'Vigilant' as smoking indoors could endanger the lives of other people and staff. We asked four members of staff about these risks, only one member of staff was aware the person was required to hand in their smoking material to staff at night but had not asked them to do so. None of the staff we spoke with who worked nights, had ever asked this person to hand in their tobacco or lighter. When we brought this to the attention of the registered and house managers, they were unaware of the risks associated with this person smoking or the guidance provided in the person's risk management plan. The registered manager assured us these risks were no longer present and told us they would undertake a review of all risk management plans.

We reviewed the home's fire safety precautions. We found people living at the home did not have personal emergency evacuation plans (PEEP) in place. The purpose of a PEEP is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. This meant staff did not have all the key information they needed to assist people to leave the building in the case of an emergency. Records showed that routine checks on fire equipment and premises safety were being completed. Staff had completed fire training and the house manager had undertaken additional fire warden training. Following the inspection, the registered manager wrote to the commission and confirmed that PEEP's were now in place.

Some people were assessed as being at high risk of becoming aggressive. Staff had received training in managing this. Where staff needed to carry out physical interventions, care plans guided staff to use the policy on physical intervention. However, no one could locate this policy. The lack of guidance potentially placed both people and staff at risk of harm.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff to meet their needs and keep them safe. We saw staff had time to spend with people on a one to one basis and support them to attend appointments, go shopping and socialise. Staff were flexible when there were shortages such as sickness; this provided continuity for people. There was a "bank" of staff available to provide short-term cover minimising the use of agency and impact

this might have on people living at the home. Staff told us they were usually sufficient staff on duty to meet people needs, but felt that at times the 'Community' had been slow to recognise the need for extra staffing when people's support needs had increased. For example, staffing had been slow to increase when staff had recently supported a person's stay in hospital.

We discussed staffing levels with the registered manager who told us there was sufficient staff on duty to meet people's needs. However, they did not have a system for determining how many staff were needed in relation to the number of people who lived in the home or their level of dependency.

We recommend the provider use a suitable tool to determine people's level of dependency to ensure that staffing levels are sufficient to meet people's assessed needs.

People told us they felt safe living at 2 Seymour Terrace. One person said, "it's alright" another said, "I do feel safe it's my home I'm happy here." Relatives were extremely positive about the care and support people received. One relative said, "It's the best place we found and we visited many, we would be lost without it its [person name] home and he's happy." Another said, "Absolutely I have no concerns about [person name] safety."

People were protected from the risk of harm. Staff received training; they knew what actions to take if they were concerned, and were confident action would be taken. They knew how to escalate their concerns outside the organisation if they needed to.

People were protected as the home had in place safe recruitment processes. Staff told us as part of their recruitment they had spent a 'taster day' at the home. This allowed people who lived in the home to meet them and feedback whether they would feel comfortable with them working at the home. We looked at the recruitment files for four staff and found checks had been undertaken prior to their employment. For example, Disclosure and Barring (police) checks had been completed. This helped reduce the risk of employing a person who may be a risk to people who use care and support services.

People received their medicines when they needed them and in a safe way. People's medicines were administered and disposed of appropriately and securely. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way. Staff told us they had received training in the safe administration of medicines and records confirmed this. We checked the quantities of a sample of medicines against the records and found them to be correct.

People were encouraged to manage their own medicines and people living at the home were working towards managing their own medicines independently and were supported by staff to do this safely. For instance, one person was supported to dispense their own medicines from a blister pack and completed a medication administration record to confirm they had been taken.

The home was clean, maintained and there were no unpleasant odours. There was an on-going programme to redecorate and make other upgrades to the premises when needed. Staff were aware of infection control procedures, and had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection and had received training in infection control.

Accidents and incidents were recorded and reviewed by the provider's health and safety manager. They collated the information to look for any trends that might indicate a change in a person's needs and to ensure the physical environment in the home was safe. Systems were in place to ensure equipment was

regularly serviced and repaired as necessary. Appropriately, skilled contractors had completed all necessary safety checks and tests for instance gas safety checks and electrical testing.

Requires Improvement

Is the service effective?

Our findings

People who lived at 2 Seymour Terrace had needs relating to their mental health, which potentially affected their ability to make some decisions. We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA). We found the home was not working within the principles of the Act and was not taking appropriate action to protect people's rights.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training and records showed people were involved in all aspects of their care, attended regular review meetings, and had access to their records.

People's support plans demonstrated their consent and views were sought in relation to decisions being made on their behalf, which indicated the home was working in line with the principles of the act. However, not all records we saw reflected the decisions being made, or why they had been made. For instance, records for one person showed the finance department of the 'Community' acted as a corporate appointee for this person's finances. There were no records to show the rationale for this decision, no mental capacity assessment to show that the person did not have capacity to manage their own finances or that this was being carried out in the person's best interest.

Where the home held or managed people's monies and/or bankcards. Staff told us this was in place to support the person to remain safe. Again, there were no mental capacity assessments to show this person did not have capacity to manage their own finances. There were no records to show the rationale for these decisions, or whether this was being carried out in their best interests. Records we saw indicated that finances were very important to this person and 'feeling he has access to them and control over his finances can have a big impact on his mood and his interactions with others'.

We discussed what we found with the registered manager. They agreed that records regarding people's financial arrangements were unclear and assured us they would take action to address this.

We looked at how the home managed this person's monies. Records showed staff obtained receipts for all money spent and checked balances daily. We checked a sample of these records and found them to be accurate. We asked to see a copy of the person's bank statement in order to check the balance in their account against the records held by the home. We found a number of people's monies were held in the same central account. This was a non-interest yielding account, which meant people were not receiving the interest they were due. There were no records to show that people had been asked/or involved in choosing which type of account their monies were held in. This meant people and did not have a choice in which type of account their monies were paid into and as a result were not receiving the interest they were due.

We discussed what we found with the registered manager and head of care who acknowledged the current

arrangements were not satisfactory and assured us they were working with people, families and the local authority to make the necessary changes.

Failure to gain consent from people, or where people were unable to give consent, involve relevant health or social care professionals in best interest decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time the inspection, no one living at 2 Seymour Terrace was subject to a DoLS application. Staff told us some people living at the home did have restrictions placed upon them under the Mental Health Act by way of a Community Treatment Order (CTO). A Community Treatment Order contains a set of rules / guidelines. This allows a person who has been detained in hospital for treatment to leave hospital (discharged from detention) and get treatment in the community.

Records for one person living at the home showed there were various restrictions in place, which placed restrictive conditions on the times this person could leave the home. Records showed these restrictions were discussed with external professionals every three months as part of this person's formal discharge arrangements. We found there was no legal basis or framework in place to support these restrictions.

We discussed what we found with the registered manager who told us they had been made aware that a recent ruling had deemed any restrictions being imposed on people under a conditional discharge had no legal basis. A multi-agency (professionals) meeting had been arranged, to discuss the arrangements in place and agree what action should be taken.

Depriving someone of their liberty for the purpose of receiving care or treatment without lawful authority is a breach for Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had confidence in the staff supporting them and felt staff were well trained. Healthcare professionals were confident staff had the skills and knowledge they needed to support people safely. One healthcare professional said, "I have complete confidence, the reports from staff are invaluable to me as a clinician."

Records showed newly appointed staff undertook an induction programme, which followed the Care Certificate framework. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. The induction included a period of working alongside more experienced staff until they had developed their skills sufficiently to support people living at the home. There was a comprehensive staff-training programme in place and staff confirmed they received regular training in a variety of topics. These included medication, first aid, fire, food hygiene, equality and diversity, Mental Capacity (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding of vulnerable adults. Other more specialists training included Mental health awareness, Personality disorders, Autism, conflict resolution and breakaway.

Staff received regular supervisions and annual appraisals. Staff told us they felt supported in their role. All staff felt there was an open door policy where they could approach the manager or senior staff for advice at any point for guidance and support. Staff felt they worked well as a team, and told us they all had different skills and experiences which they used to support each other and felt they worked well as a team. One member of staff said, "there was always a good exchange of ideas," another said "you feel listened to and

your opinions are valued."

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People's support plans included details of their appointments and staff we spoke with knew people well. People's mental and physical health was monitored by staff and we saw, where concerns had been identified, people were referred to or reviewed by an appropriate healthcare professional. Staff told us, and records confirmed, people were supported to attend mental health reviews and had regular contact with their health care co-ordinator, GP's or consultant psychiatrists. The registered manager told us that in addition to people being able to access local health care services people were supported internally via the Head of Care who was a qualified social worker.

The 'Community' employed an independent consultant psychiatrist who was available to see people on a weekly basis, liaised directly with people's individual GP's, and was available to provide support and guidance when needed. We asked people if having this support was helpful, One person was very positive about [consultant psychiatrist name] saying "We have a good relationship, she gets things done." Staff were aware of when to seek advice from people's mental healthcare professionals and felt confident doing so. Healthcare professionals we spoke with were positive about the home and the services it provided. One healthcare professional said the home was an "excellent asset to the local community."

People were encouraged to be as independent as possible with planning, shopping and cooking their own meals. A large kitchen was freely accessible and well stocked with tea, coffee and soft drinks. People helped themselves to breakfast and lunch and people were able to help themselves to food and snacks throughout the day.

We saw where people did not want to cook, because they were unwell, meals were provided. Staff usually cooked an evening meal but people were freely able to self-cater if the wished to do so. We asked people what they thought of the food provided by the home. One person said, "the foods alright" another said, "I am able to choose the things I like I shop and cook myself most days." Staff said, "we always ask people what they would like to eat; you often end up cooking a couple of different options."

Staff knew people's food preferences well and told us how they supported people to follow a healthy balanced diet. Staff were knowledgeable about how to support people who might have historically a difficult relationship with food and understood how this might affect their mental and physical health and wellbeing. Where this was the case, people's support plans highlighted where risks with eating and drinking had been identified and risk assessments guided staff to monitor, encourage and support people during this time. For example, ensuring foods they liked were prepared and readily available.

Good

Is the service caring?

Our findings

People who lived at the home and their relatives spoke highly of the registered manager, staff and the support they provided. One person said, "they know and understand me and I know them," another said if "I wasn't happy I would leave, we all get on pretty well." Relatives consistently gave us positive feedback about the registered manager; One relative said the registered manager is like an "angel with wings." Another said "All the staff are so dedicated to their jobs I'm so impressed with how they support [person's name]."

People's needs in terms of their mental and physical health, race, religion and beliefs were understood and supported by staff in a professional and non-discriminatory way. Staff supported people to make choices even when this was difficult, for example if they had relationships or behaviours, which might have a negative impact on their health. Staff were supportive, caring and showed genuine fondness and positive regard for the people they supported. When staff spoke with us about people, they did so in a respectful and compassionate manner. Staff told us how much they enjoyed working at the home. Comments included "it's a good place to work", "people come first" and "we share a space." One staff member said, "I can't speak highly enough about what we do, both managers are excellent. Everyone works well as a team and will go that extra mile."

Staff were knowledgeable about the people they supported. Staff were able to tell us about people's background /histories and event's in their lives, which had led them to needing support at 2, Seymour Terrace as well as their goals, aspirations and what was important to them now. Managers and staff understood and recognised people's individual needs and worked alongside people in a positive way to help them identify the triggers that might indicate they were becoming unwell and learn how to manage these in the future. For instance, poor sleep patterns, isolation or the use of alcohol or illicit drugs.

People told us they felt they had control over their lives. Staff explained how they empowered people to manage their own needs independently and supported them through listening. Staff gave people time to reflect and develop skills for the future. For instance by supporting people to develop their life skills or developing ways of managing anxiety or conflicts that might arise from social setting. One member of staff said, "having time to share activities that people enjoy such as music or fishing allows us time to build and develop therapeutic, trusting relationships which are so important." A healthcare professional said "2 Seymour Terrace provides a compassionate respectful home for people. At the same time it provides challenges for people to aspire to, to empower them and ensure they progress towards independence."

People told us they were able to lock their rooms if they wished and their privacy and dignity was respected. Where staff needed to talk to or about people, conversations were held in private or discreetly in communal areas. Staff knocked on people's doors and sought permission before they entered their personal space (bedrooms).

People's personal and private information and health care records were kept safely and securely. People we spoke with told us they were involved in all aspects of planning their care and were included in any meetings held about them. Records showed that people attended regular review meetings; people's views were

actively encouraged and recorded. People were mostly able to come and go as they pleased and people's friends and family were welcomed and encouraged to visit.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to coming to live at the home. This formed the basis of a support plan, which was further developed after the person moved in and staff had got to know the person better. The registered manager told us this pre-admission assessment enabled them to consider the current mix of people living at the home and helped ensure the home was able to meet their needs.

We looked at the care and support records for all the people living at the home. We found people's records were not always written in a person centred way, contained outdated/ misleading terminology, were not always accurate, and did not always provide staff with sufficient detail to support the people's needs. For example, records for all four people contained references to 'unescorted leave'. This would imply that there were times when people living at the home were not able to go out without some level of supervision or were restricted in some way. We discussed this with the registered and house managers who assured this was not the case, but accepted the language was misleading and not person centred.

Records for three of the people living at the home guided staff to undertake regular tests for illegal substances (drugs). Records showed for two of the people this was a legal requirement of their Community Treatment Order (CTO). However, records for one person stated 'I accept that I must have a drugs test randomly when asked and this must be done under observation'. There was no guidance or information provided to staff as to why this was a requirement of their placement, what would constitute a random testing regime or what signs and systems would potentially indicate that this person was under the influence of illegal substances and therefore required to submit to a test. Records showed staff had been testing this person on a weekly basis since November 2017. During this time, they had only recorded one positive test result. We looked at this person's 'contract/ statement of terms and conditions' and found this did not mention that the person would be required to submit to random drug testing as a condition of the placement. We discussed what we found with the registered manager who was unable to tell us why staff were carry out weekly drugs test and assured us that they would review the need for testing as well as the guidance provided.

Records for another person indicated in order to 'remain in good mental health they should refrain from drinking alcohol whilst out and that it was advisable for them to be accompanied by a member of staff or a friend at this time'. As part of this person's risk management plan staff were advised this person was only allowed to have 'one pint of beer a week, accompanied by staff or whilst at a friend's, or on special occasions by prior agreement. If this person returns from unescorted leave intoxicated this will be reviewed'. There was no guidance or information provided to staff as to why this was in place, how the figure of one pint had been reached, on what basis this review would take place or by whom.

We looked at the homes 'contract/statement of terms, conditions,' This stated that the consumption of alcohol within reasonable limits was recognised as a normal and positive part of social life. This did not contain any guidance or information to inform people living at the home that should they become intoxicated their rights to leave the home freely would be reviewed or potentially restricted.

We discussed what we found with the registered and house managers who assured us this person's ability to leave the home freely would not be unduly restricted. At present there were not any particular concerns about this person's alcohol consumption and confirmed that they would update this person's care records.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person – centred care.

People told us they had been involved in identifying their needs, planning their care and making decisions about how their needs were met. Others aspects of people's care records contained detailed information about people's health and social care needs. They were written using the person's preferred name and reflected how the individual wished to receive their care. Care and support plans contained information about what the person could continue to do for themselves and how they liked to be supported. Each section of the plan covered a different area of the person's care needs, for example, personal care, physical health, independent living skills, communication, mental well-being and emotional support.

People's wishes and unique goals were central to the care and support provided and there was an understanding that staff were there to enable and support people to develop skills to manage their own wellbeing and life skills. People's support plans guided staff on how to support people in managing their mental health in a way, which caused the least amount of distress to the person, should they deteriorate or suffer a relapse. Each person's support care plan contained information on the signs and triggers that might indicate that the person was becoming unwell or deteriorating and any action staff should take.

Staff we spoke with were skilled in delivering care and support and had a good understanding of people's individual needs but were not always aware of the associated risks. Staff gave us examples of how they had provided support to meet the diverse needs of people living at the home including those related to disability, gender, ethnicity, faith and sexual orientation. Each person's support plan contained important information about people who mattered to them as well as information about people's backgrounds and histories. This gave staff the opportunity to understand a person's past and how it could influence who they were today and enabled staff to support people to maintain their personal relationships.

The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment, or sensory loss. All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. CQC have committed to look at the Accessible Information Standard at inspections of all homes from 01 November 2017. The manager was aware of the Accessible Information Standard and we saw that people's communication needs were clearly recorded as part of the home's assessment process. This information was then used to develop communication plans, which would indicate people's strengths, as well as areas where they needed support. This approach helped to ensure people's communication needs were met.

Records showed people had signed their support plans and people told us they had contributed to their development and were aware of their content. People and their relatives where appropriate were involved in reviews and were able to express their views about the care and support they received. We saw people's needs were reviewed on a regular basis with external professionals. Records showed the registered manager prepared detailed summary on aspects of people lives as well as any personal views or comments they wished to make or issue they would like to discuss as part of this process. For example, people's care records showed the progress they had made in relation to self-care, daily living skills, budgeting as well as their vocational interest / hobbies. However, the outcomes of these reviews were not always being recorded. Records for one person showed this person had expressed a wish to discuss his current financial arrangement. We asked the manager what the outcome of this discussion had been, as they were not

contained within the records we saw. The house manager explained they had not been present during this review and was unable to tell us the outcome as it had not been recorded.

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated. People's support plans contained detailed information about people's hobbies and interests. People had many different opportunities to socialise and take part in activities if they wished to do so. People routinely went to a variety of pubs, open mike night's restaurants, cinema, and shops as well as on holiday if they wished to do so. For example, one person told us about his recent holiday, which he thoroughly enjoyed and was planning a trip to Plymouth to see a show. Another person who had a passion for music regularly hosted a show on his local radio station. We heard throughout the inspection staff and people taking about what they were up to or making plans for example, going to the pub to watch football or taking part in jamming session.

In addition, The Community provides a range of activities, which have been developed at the request of people who use their services. The Community produces a monthly activity programme and people are freely able to choose which activities they want to participate in for example, climbing , cookery, art and creative writing, and music sessions where people were able to lean to play the guitar or piano. People told us they enjoyed taking part in these activities and we saw the feedback received from people following 2017 programme was very positive. For example, "It's all great stuff", "very good" and "good time on all the walks and good destinations." One person commented, "the allotment gives me freedom away from the house and something to do."

People were aware of how to make a complaint, and felt able to raise concerns if something was not right. One person said they would speak to the manager or staff if they were unhappy. The home's complaints procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated, and responded to. None of the people, relatives or staff we spoke with had needed to make a complaint, but felt confident the manager would listen and respond to any concerns they might have.

Requires Improvement

Is the service well-led?

Our findings

2 Seymour Terrace was previously inspected in August 2015 and was found to be meeting the regulations inspected at that time. At this inspection, we found some aspects of the home were not well led.

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided. The provider used a variety of systems to monitor the home. These included a range of meetings, audits, and spot checks, for instance checks of the environment, medicines, infection control, health & safety, and accident and incidents.

Although some systems were working well, others had not been effective, as they had not identified the concerns we found during this inspection. For example, although people's care was reviewed on a regular basis the outcomes were not always recorded and there was no system in place to monitor people's care records. We found people's records contained outdated/ misleading terminology, were not always accurate, person centred or provided staff with sufficient detail to support people's individual needs.

People were potentially exposed to the risk of harm, because where staff had been provided with, guidance to help reduce or minimise the risks, advice was not always understood by staff or followed.

The home was not working within the principles of The Mental Capacity Act 2005 (MCA) and the systems in place had not identified that the home was not always taking appropriate action to protect people's rights.

Where the provider managed peoples monies. We found a number of people's monies were held in the same central account. This was a non-interest yielding account, which meant people were not receiving the interest they were due.

We met with the registered and house managers following the inspection, and discussed what we had found. They accepted and recognised the home needed to make a number of changes to improve the quality and support being provided.

Failure to ensure systems were effective in assessing, monitoring and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2 Seymour Terrace did have a registered manager in post, at the time the inspection they were overseeing another home owned by the same provider. An interim manager had been appointed by the provider to oversee the home in the registered managers' absence. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People, relatives and staff told us the home was well managed, and described the management team as open, honest and approachable. One person said, "He's [registered managers] ok I can talk to him about

anything". Staff were positive about the support they received and told us they felt supported and valued by both managers. Relatives told us the home was well run and they had complete confidence in the manager.

The management team told us their vision for the home was to create a safe and supportive environment that aims to empower people to take responsibility for managing their own recovery and move towards more independent living. Staff had a clear understanding of the values and vision of the home and told us how they supported people to be as independent as possible and live their life as they chose. Staff spoke passionately about their work and the people they supported and were proud of people's achievements.

Staff told us both managers were available should they need them and took an active 'hands on' role within the running of the home. The registered manager had a good knowledge of the people supported by the home. The management and staff structure provided clear lines of accountability and responsibility, which helped ensure staff at the appropriate level made decisions about the day-to-day running of the home. Staff knew whom they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty, through handover meetings and regular staff meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns. There was an out of hour's management rota, which ensured there was always a senior member of staff to contact for support. Specialist support and advice was sought from external health and social care professionals when needed. One healthcare professional said, "the registered managers' ability to relate to staff and people creates a happy working environment. Their strong leadership makes staff and residents feel secure."

People told us they were encouraged to share their views and were able to speak to the registered manager or members of senior management team if they needed to. However, we found the home had no formal way of recording this information apart from in relation to activities. Senior managers regularly carried out unannounced spot checks and audits of the home. These included speaking with people who lived at the home in order seek their views, and auditing all aspects of health and safety. The registered manager told us the Community held managers meetings regularly, these were an opportunity for managers to discuss their homes, and address any concerns. For example recruitment, people, health and safety, policies and procedures and best practice.

The registered manager kept their knowledge of care management and legislation up to date by using the internet and attending training sessions. They were aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. The registered manager had notified the Care Quality Commission of all significant events, which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not appropriate, did not meet their needs, or reflect their preferences. Regulation 9(1)(a)(b)(c) (3)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment The provider had failed to ensure people were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority Regulation 13(5)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and processes in place to assess, monitor, and mitigate risks to people. Records were not accurate, up to date, complete. Regulation 17 (1)(2)(a)(b)(c)