A Wilks

Seaton Hall Residential Home

Inspection report

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Date of inspection visit:
06 March 2018

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

This inspection took place on 6 March 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

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

Seaton Hall Residential Home accommodates up to 29 older people who require personal care in one adapted building. At the time of our inspection, there were 23 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Seaton Hall was last inspected by CQC in January 2017 and was rated Requires improvement overall. At the inspection in January 2017 we identified the following breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (Good governance). This was because the provider's governance system had not always been effective in identifying or addressing improvements to the service. At this inspection we found improvements had been made in all the areas identified at the previous inspection.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks.

The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. Staff were suitably trained and received regular supervisions and appraisals.

The provider carried out relevant vetting checks when they employed staff. However, there was no record of

what documents had been checked to confirm the proof of identity of new staff. We have made a recommendation about this.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Seaton Hall Residential Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and support plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests, and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint however there had been no formal complaints recorded at the service.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys. People and family members told us the registered manager was approachable and visible.

The registered manager completed a monthly audit of the service. The provider visited monthly however these visits were not recorded. We have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and relevant vetting checks had taken place for new staff.

Accidents and incidents were appropriately recorded and investigated, and appropriate risk assessments were in place.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People's needs were assessed before they began using the service.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

People had access to healthcare services and received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Care records were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had good links with the local community.

Seaton Hall Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 March 2018 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with seven people who used the service and three family members. We also spoke with the registered manager, deputy manager, activities coordinator and two members of staff.

We looked at the care records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

People and family members we spoke with told us they thought Seaton Hall Residential Home was a safe place. A person who used the service told us, "I feel very safe; I have my call bell near to hand if I need anything." A family member told us, "My [relative] is definitely safe living here, staff are always around. No-one can get in and no-one can just walk out." Another family member told us, "My [relative] is very safe. The doors are locked, and you have to sign in and out."

At the previous inspection we found risk assessments about people were not easily accessible to staff. At this inspection we saw risk assessments were stored in people's individual care records alongside support plans. These included the risk of self-neglect, malnutrition and dehydration, medicines, infections and physical health problems, personal safety, manual handling and social isolation. Each risk assessment recorded the identified risk, who might be affected, how they might be affected, what measures were currently in place to reduce the risk and whether any additional measures were required.

Accidents and incidents were appropriately recorded. Monthly audits were carried out to identify any trends and lessons learned. For example, one person was independently mobile but due to a recent fall, staff were advised to walk with them for a couple of steps when they first attempted to walk from a seated position. For another person, staff were to ensure their night light was left on and a drink was within reach when they were in bed to reduce the risk of falls. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Regular maintenance and health and safety checks were carried out and were up to date. Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date.

Risks to people's safety in the event of a fire had been identified and managed, for example, a fire risk assessment was in place, fire drills took place regularly and regular checks were carried out of firefighting equipment. The service had an emergency and a contingency plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding adults' policy, which provided guidance on identifying and reporting incidents. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The registered manager understood their responsibilities with regard to safeguarding and staff received training in the protection of vulnerable adults.

Staff recruitment records showed that appropriate checks had been undertaken before staff began working

for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people from working with children and vulnerable adults. Copies of application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. Proof of identity was obtained from each member of staff. However, these were visually checked and details of what was actually checked was not recorded in the staff files.

We recommend the provider records what documents have been checked to confirm the proof of identity of new staff.

We discussed staffing levels with the registered manager and looked at staff rotas. A dependency tool was used to calculate staffing levels and staffing levels varied depending on people's needs. The registered manager told us agency staff were not used at the home. The service had one bank staff member and domestic staff were also trained as care staff so could cover any absences. Staff, people who used the service and family members did not raise any concerns about staffing levels at the home and there were sufficient numbers of staff on duty during our visit.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and new carpets had been put down in some of the communal areas. Refurbishment of the home was ongoing and the registered manager told us this would include re-carpeting the remainder of the home.

The home was clean and there were no unpleasant odours. Appropriate hand hygiene gel and personal protective equipment (PPE) were in place and in use. A member of staff was the home's infection control champion. They had received additional training and carried out checks on infection prevention and control, including observations and spot checks of staff. This meant people were protected from the risk of acquired infections.

We looked at the management of medicines and saw medicines were safely stored inside a locked room. The temperature of the room was recorded to ensure medicines were stored at a safe temperature. Regular medicines audits took place, and staff who administered medicines were appropriately trained and received annual competency checks.

Medication administration records (MARs) we saw were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Records included GP contact details and details of any allergies. This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A person who used the service told us, "I need help with my shower and the carers are really confident and know what they are doing." Another person told us, "Yes, the staff seem to know what they are doing. I have no problems with them." A family member told us, "The staff know what they are doing, they are absolutely marvellous."

Some of the people who used the service were living with dementia. At the previous inspection we found the premises had no design features or adaptations to support people who were living with dementia. We looked at the design of the home and found the service now incorporated environmental aspects that were dementia friendly. For example, communal bathroom and toilet doors were painted a different colour and were appropriately signed so that people could identify them. Corridor walls were decorated to provide people with visual stimulation. For example, a memory wall included old photographs of the local area. The home had a 'Reminiscence lounge' that included old furniture, ornaments, a mannequin that people dressed in different clothes and a record player. The activities co-ordinator told us they had contacted the local newspaper to advertise to the public for donations to be able to create this room. The registered manager and a member of staff were dementia champions and had completed specialist training in dementia. Following this training they had decorated the dining room walls and tables in specific colours to stimulate people at meal times.

We saw the majority of staff mandatory training was up to date and where it was due, it was booked. Mandatory training is training that the provider deems necessary to support people safely and included health and safety, fire safety, first aid, food hygiene, infection control, moving and assisting, safeguarding, and hand hygiene. Additional training was provided depending on the role of the staff member. For example, mental capacity, diabetes and safe handling of medicines.

New staff completed a thorough induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans.

People had access to a choice of food and drink throughout the day. We observed lunch and saw staff supporting people who required assistance and providing prompts when required. A pictorial menu was in place, which included breakfast, healthy options, lunch and dinner. People were given a choice of hot and cold drinks. People were asked if they wanted a dignity tabard to avoid food spoiling their clothes. We did

not observe staff asking people what they wanted to eat but the registered manager told us people were informed in the morning of what was available and alternatives were provided for anyone who did not like what was on the menu.

A person who used the service told us, "The food is not too bad, they are always bringing hot drinks and cake during the day." Another person told us, "I go downstairs for my meals, the food is great. If you don't like something you can choose an alternative." A family member told us, "My [relative] loves the food, they get a choice of what they want to eat. They also get snacks throughout the day."

Care records described people's food and drink preferences, and the level of support they required from staff. For example, one person's record stated, "At mealtimes I will choose what I would like", "I need to be supported by one staff", "When I do eat food myself I still need staff to supervise me. Sometimes I will chew my food and store it within my cheeks and forget to swallow" and "I do need to be reminded to drink fluids." People had food monitoring logs that recorded the meals and snacks they had eaten, the amount, and any choices made. These records were up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw DoLS had been appropriately applied for and a record was kept of when they had been authorised. Mental capacity assessments had been carried out and any decisions taken in people's best interests had been recorded.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date and showed the person who used the service had been involved in the decision making process.

People who used the service had 'Hospital passports' in place, had access to healthcare services and received ongoing healthcare support. The aim of the hospital passport is to provide hospital staff with important information about them and their health if they are admitted to hospital. Care records contained evidence of visits from external specialists including GPs, community nursing teams, opticians and phlebotomists. People and family members told us staff were very proactive at requesting support from health care professionals when it was needed. A person who used the service told us, "I rang for the nurse who immediately called the doctor. The doctor came to see me that same day." A family member told us, "My [relative] was feeling unwell and the staff called the community nurse straight away."

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Seaton Hall Residential Home. A family member told us, "Staff are very kind and caring." Another family member told us, "Staff are totally great, angels they are. If ever you need anything they are there for you." Another family member told us, "Staff are very caring, they know all about my [relative]. They make things homely for them."

We observed staff interacting with people at every opportunity. We saw staff bending down to talk to people so as not to appear threatening and chatting to them calmly and reassuringly in a kind and friendly manner. We observed friendly and comforting touches from staff on people's faces and arms. One person was walking up the corridor hand in hand with a member of staff, they were chatting and joking with each other.

People were well-presented and their clothes were ironed, clean and tidy. We saw one person had their hair cut and blow dried and their nails painted and manicured. We observed staff making a fuss of a person who was celebrating their birthday. The staff made the person feel special, sang "happy birthday" to them and commented on the flowers they had received.

Staff were always visible in the communal lounges and were in and out all the time. They chatted to people and asked if they were okay. We observed a person who became very distressed. A member of staff who was nearby intervened immediately and took the person for a walk around the home. The person returned feeling much better.

We saw a present had been brought in by the family members of a person who used to live at the home. The card on the present stated, "We wanted to say an extra thank you to all the staff at Seaton Hall for all the wonderful care you gave [name] during the many years she lived there." Another thank you card stated, "Many thanks to the lovely staff at Seaton Hall for looking after [family member]. He was treated with great care and compassion and it is very much appreciated."

People's individual choices were recorded and records described how staff were to respect people's privacy and dignity. For example, "I like to get supported with my bed bath on a morning between 8am and 8.30am. I am normally awake during that time so they [staff] will give a gentle knock before entering to respect my privacy", "I like the staff to ask me if I would like to get dressed. If I agree they will close the door", "When staff have supported me to remove my nightwear they will cover me over with a long towel to maintain my dignity" and "Once I am in my chair, I like the staff to cover my legs with a blanket to maintain my dignity."

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. We asked people whether staff respected their privacy and dignity. One person told us, "The staff are dead good, they always close the door when I am having a shower." Another person told us, "They always knock on my door before coming in, even if I have the door open they still knock." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider

promoted dignified and respectful care practices to staff.

People were supported to be independent where possible. For example, some people were independently mobile around the home or could eat and drink independently. However, staff were on hand to provide assistance to those who required it. A person told us, "I am quite independent and do most things by myself. I do need some help when I have a bath." Another person told us, "I like to do things myself, but the staff will help me if I need it." Another person told us, "I can get around ok. I try and dress myself but staff sometimes have to finish it off."

People had communication support plans in place that described how people preferred to communicate and what their individual needs were. For example, whether the person understood verbal requests or signs and gestures, and whether they used pictures, photographs or symbols to aid communication.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. Advocacy information was available in the foyer. The registered manager told us none of the people using the service at the time of the inspection had an independent advocate.

Good

Is the service responsive?

Our findings

Care records we looked at were regularly reviewed and evaluated. The care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account.

Each person had a 'My personal care profile'. This was described as, "A partnership between the residents, their family, representatives, friends and carers." We saw these had been written in consultation with the person who used the service and their family members and included a description of the person, details of their life history, who and what was important to them, how they preferred to spend their time, whether they had any cultural or religious needs, details of their individual needs and how best to support the person. People and family members told us they had been involved in writing care records.

Support plans included mobility, breathing, hygiene, continence, sleep, hearing, sight, speech, safety, allergies, nutrition and fluid, and dietary requirements. For example, one person was at risk of pressure damage and was supported with their personal care by staff. They had appropriate equipment in place, including an air flow mattress and staff were instructed to ensure it was in good working order. The person was also supported by the community nursing team who visited twice per week to apply dressings to affected areas. Appropriate risk assessments were in place and were up to date.

Daily care logs recorded whether people's individual needs had been completed that day and included details of food and fluid intake, night time checks, pressure area and continence, oral care and details of any activities the person took part in. Records we saw were up to date.

None of the people using the service at the time of our inspection were receiving end of life care. The registered manager told us conversations took place with people and family members regarding their end of life needs, for example, funeral arrangements and we saw these were recorded.

We found the provider protected people from social isolation. People were able to maintain friendships with friends and family and there was unrestricted visiting in the home. People were very positive about the activities available to them. One person told us, "[Activities coordinator] is lovely, she makes sure that we don't get bored." Another person told us, "There is always something to do like bingo and making cakes." Another person told us, "I have never baked a cake in my life, but I am making bread now."

People were given the choice of whether they wanted to take part in activities. One person told us, "I like to watch TV in my room. I don't join in any of the activities." Another person told us, "I watch TV and I go downstairs for a smoke and a cup of coffee. I don't join in with the activities, I keep myself to myself. [Activities coordinator] always asks me though."

On the morning of our visit we saw people playing skittles in the lounge. It was a pleasant atmosphere with lots of talking between people and staff. Old time music was playing in the background. During the afternoon there was reminiscence and nostalgia with historic photographs of the local area being shown by

the activities co-ordinator. Later in the day a DVD of the local area was shown on the television.

People were able to take part in external activities, such as accessing cafés and tea rooms in the local area and walks along the sea front. The registered manager told us trips to Beamish Museum and Eden Camp were planned.

The provider's 'Comments, complaints and suggestions' policy was on display in the home and included guidance on how to make a complaint and how long it would take for the complaint to be dealt with. There had not been any complaints recorded at the service in the previous 12 months. However, people and family members we spoke with were aware of how to make a complaint but did not have any complaints to make.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since May 2017. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. Ongoing refurbishment was taking place at the home and the registered manager told us they had applied for funding for a sensory garden.

At the previous inspection we identified the provider had not always sent statutory notifications to CQC. A statutory notification is information about important events which the service is required to send to the Commission by law. At this inspection we found the provider was meeting the conditions of their registration and had submitted statutory notifications in a timely manner. At the previous inspection it was also identified that the provider's website and statement of purpose contained some inaccurate information. At this inspection we found the website and statement of purpose had been corrected.

The service had good links with the local community. People accessed the library and visited a tea room and local restaurants. Primary school children visited the home at Christmas and Easter, and local entertainers were regular visitors to the home.

The service had a positive culture that was person centred, open and inclusive. The registered manager told us they stayed at the home to assist with the evening meal and wanted to be "a face they [people] can talk to". People and family members told us the registered manager was very approachable and visible, and they would have no concerns in approaching him if they had any worries or concerns. A family member told us, "I don't know him [registered manager] by name, but he has made a good job of this place." Another family member told us, "Yes, I know who the manager is. He is very nice. He is hands on; he helps with setting the tables for tea." Another family member told us, "He is great, I see him around the home. He is very pleasant."

Staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff meetings that took place monthly. Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. One staff member told us, "We get lots of support" and "Everything is dealt with in confidence." Another staff member told us, "It's a lovely place to work."

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The registered manager completed a monthly management report that included checks of the building and whether there were any maintenance issue, records relating to people who used the service, staff supervisions, training, meetings and spot checks, and records of any visits by external commissioners and regulators. Where any actions were identified, these were recorded. The registered manager also maintained a matrix for all the people who used the service. This recorded when DoLS, DNACPRs, and reviews were due.

The registered manager told us the provider visited the home on a monthly basis and conducted their own

walk around, which included observations and discussions with people and staff. However, these visits were not recorded.

We recommend the provider documents their visits to the home to evidence the auditing process that takes place.

Residents' meetings took place regularly. Subjects discussed at these meetings included the menu, the décor of the home, complaints and activities. Feedback sheets were given to family members to see if there was anything that could be improved upon. The provider also produced a regular newsletter that provided information on activities and events at the home, and updates on the service.

People were asked to complete an annual survey on the quality of the service. This included questions on the accommodation, staff, meals, complaints, activities and overall comfort. Visitors to the home were also provided with a survey. The results of the surveys were analysed to identify whether any corrective actions were required. Comments from the most recent surveys included, "All the staff do a very good job" and "We are still perfectly happy with the care [family member] gets at Seaton Hall." There were no negative comments. This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.