Hartlepool
Borough Council

ADULT SERVICES & PUBLIC HEALTH
Quality Standard Framework

Organisation	Seymour House Ltd
Home	Seymour House
Responsible Person	Steve McDermott
Date of Report	15-MAY-2026

Commissioned Services Team, Adult Services & Public Health

Overview of Home

Seymour House is a nursing home providing care for up to 20 residents with mental health needs. The overall standard of care delivered at the service is good, with staff consistently demonstrating kindness, compassion, and respect towards residents. Many members of staff have worked at Seymour House for several years, contributing to a stable, experienced workforce and fostering a calm, supportive, and welcoming environment for both residents and staff. The home operates in an open and transparent manner, particularly in relation to safeguarding. Any issues or concerns are identified promptly and reported without delay, ensuring the ongoing safety and wellbeing of residents.
Care plans are person centred, reflect the needs and wishes of the residents and are updated in a timely manner. Staff training has improved over the last period with the majority of staff completing all mandatory training. A Formal Lessons Learnt process is not in place but the home has proven that they respond appropriately to incidents and analyse and adapt practices accordingly.

Summary of Outcomes

Seymour House

Date of Report 15 May 2026

	Determination
Person Centred Care	
1 - Assessment & Review	Outcome "Fully Met" – 15 May 2026
2 - MCA & Consent	Outcome "Fully Met"– 21 February 2024
3 - DoIS	Outcome "Fully Met"– 21 February 2024
4 - Nutrition & Hydration	Outcome "Fully Met"– 15 May 2026
5 - Promoting Dignity, Autonomy & Choice	Outcome "Fully Met"– 21 February 2024
Safe Care and Treatment	
6 - Safeguarding/Understanding Safeguarding	Outcome "Fully Met"– 21 February 2024
7 - Medication	Outcome "Fully Met"– 15 May 2026
8 - Infection Control	Outcome "Fully Met"– 21 February 2024
9 - Premises & Equipment	Outcome "Fully Met"– 21 February 2024
10 - Health & Safety	
11 - Moving & Handling	Outcome "Fully Met"– 21 February 2024
Governance	
12 - Leadership & Management	Outcome "Fully Met"– 15 May 2026
13 - Staffing, Recruitment, Support & Learning	Outcome "Fully Met"– 15 May 2026
14 - Quality Assurance	Outcome "Fully Met"– 15 May 2026
15 - Complaints	Outcome "Fully Met"– 21 February 2024

1 - Assessment & Review

Determination - Fully Met

All people receiving the service have a written care plan that is monitored, periodically evaluated and reviews are recorded to ensure the information is up to date and accurate.

People's physical, mental health and social needs holistically are assessed, and their care, treatment and support is delivered in line with relevant legislation and guidance, to achieve effective outcomes.

People's care records are accurate, complete, legible, up-to-date, securely stored and available to relevant staff so that they support people to stay safe.

The service ensures that people are provided with the information and understanding about their healthcare and treatment options.

People are regularly involved in monitoring their health.

People can access care, support and treatment in a timely way and referrals are made quickly to appropriate health services when people's needs change.

People contribute to planning their care and support, with their strengths, levels of independence and quality of life are taken into account.

People's care plans reflect their physical, mental, emotional and social needs and incorporate their personal history, individual preferences, interests and aspirations. Care plans are understood by staff, so people have as much choice and control as possible.

Peoples' oral health needs are met and kept under review with professional guidance sought in a timely manner when required.

The service shares appropriate information and assessments with other relevant agencies for the benefit of people who use the service.

People have the opportunity to record their preferences and choices for their end-of-life care, and this is reviewed and communicated and acted on where possible. Family, friends and other representatives are involved in planning, managing and making decisions about their end-of-life care including advanced decisions made in line with the Mental Capacity Act 2005.

The service ensures that it quickly identifies people in the last days of life whose condition may be unpredictable and change rapidly and, where required ensures that people have rapid access to support, equipment and medicines including from specialist palliative care professionals.

The service supports people's families, other people using the service and staff when someone dies.

The Home has demonstrated achievement of this outcome.

2 – Mental Capacity Act & Consent

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.
Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Source *- QSF Report 21ST February 2024*

Staff recognise when people need and want support from their carers, advocates or representatives to help them understand and be involved in their care, treatment and support and staff help people to get this support. However, a formal process to record when people have been visited, particularly those with RPR's, would make this process more robust.
The service provides information to people, their families and other carers about external bodies, community organisations and advocacy services that can provide independent support and advice about their care, treatment and support.
Staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national guidance.
People are supported and are given the information and explanations they need to make their own decisions in line with relevant legislation and guidance.
Decisions around a person's possible lack of mental capacity are assessed and recorded.
When people lack the mental capacity to make a decision, staff ensure that best interest decisions are made in accordance with legislation.
The process for seeking consent is monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance.
There are arrangements for people to be involved in decisions about managing risks appropriately including positive risk taking.
Risk management policies and procedures are in place to minimise restrictions on people's freedom, choice and control, in particular for people who lack mental capacity. However, policy information would now benefit from a full review.
Staff are trained to understand, prevent and manage people's behaviour that challenges whilst ensuring the individual is supported appropriately.
The service identifies and meets the information and communication needs of people with a disability or sensory loss. Information is recorded, highlighted and shared with others when required with the consent of the person.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

3 - DoLs

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.

Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, assessments have been undertaken to ensure the home continues to maintain processes and procedures for tracking and recording DOLS applications. The home has a matrix in place to ensure DOLS are reapplied for as required, in a timely manner. When DOLS applications have been granted, the home ensures that these are present within the care plan.

Source - QSF Report 21st February 2024

The service promotes supportive practice that avoids the need for physical restraint and where restraint is necessary, the service ensures that it is used in a safe, proportionate, and monitored way as part of a person-centred support plan. However, challenging behaviour training was last undertaken in April 2021 and staff would now benefit from refresher training to ensure their skills are up to date.
Although not currently relevant, staff would recognise when people who lack mental capacity are being deprived of their liberty and they would seek authorisation to do so when considered necessary and proportionate.
All staff had refresher training April 2023 and the service has improved in this area since the previous period of review.
All staff are trained to understand the difference between lawful and unlawful restraint practices. Action is taken to minimise the use of restraint.
There is a basic system of monitoring to ensure the person's representative maintains regular contact with the person and acts when contact is not maintained. However, a formal process to record when people have been visited, particularly those with RPR's, would make this process more robust.
No people currently living within the service are subject to DoLS authorisations so it not possible to verify how conditions are recorded within care plans.
Management has oversight on the process to ensure where a restriction may actually amount to a deprivation of liberty.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

4 – Nutrition & Hydration

Determination - Fully Met

People are involved in decisions about what they eat and drink and their cultural and religious preferences are recorded, reviewed and acted upon.

People have access to dietary and nutritional specialists to help meet their assessed needs if required.

All people currently living within the service can eat independently and do not require prompts and encouragement to eat. People enjoy mealtimes and do not feel rushed.

All people within the service have a nutritional care plan and any specific needs and risks are identified and managed in relation to their eating and drinking.

All relevant staff have completed food hygiene training and the correct procedures are in place and followed wherever food is prepared and stored.

People have accurate nutrition and hydration assessments for eating and drinking which are carried out by knowledgeable staff.

All people currently living within the service can eat independently and do not require prompts and encouragement to eat.

The service is aware of specialist diets, allergies, choking risks and lifestyle choices, and these are recorded, kept up to date and shared as appropriate.

People have access to specialist equipment in a timely manner to meet their assessed need.

Drinks are offered throughout the day and when required people's intake is monitored to ensure their assessed needs are being met. Snacks are offered outside of mealtimes and are available any time of day upon request.

People can choose the location of where they eat including the dining room, their own room or communal areas and are supported to do so.

People are offered a choice of food and drink which is served straight from the kitchen. Snacks are available throughout the day.
Residents often bring food in or order food to be delivered to the home.

Residents can choose where they want to eat their meals - care staff are supportive of all residents.

The Home has demonstrated achievement of this outcome.

5 – Promoting Dignity, autonomy and choice

Determination - Fully Met

Staff show concern for people's wellbeing in a caring and meaningful way and respond to their needs in a timely manner on a day to day basis.

The service makes sure that people, and those close to them, feel like they matter, and that staff listen to them and talk to them appropriately and in a way they can understand.

People are actively involved in developing the service including:• deciding how they choose to spend their day• planning activities and outings• decisions around personal care and how and when help is provided• devising menus and the timing and place of meals, and• people are consulted when alterations to their living space is planned.

Staff seek accessible ways to communicate with people (when their protected and other characteristics under the Equality Act make this necessary) to reduce or remove barriers.

Staff know the people they are caring for and supporting, including their preferences, personal histories, backgrounds.

Staff make sure that people's privacy and dignity needs are understood and respected including during personal care.

People receive support to be independent. Their wishes are recorded, reviewed and acted upon wherever possible.

People's relatives and friends are made to feel welcome and are able to visit without being unnecessarily restricted. There are arrangements to encourage relatives and friends to provide feedback on the service.

Processes are in place to ensure there is no discrimination when making care and support decisions.

People are supported to follow their interests and take part in activities that are appropriate to them including in the wider community.

The service ensures that people are encouraged and supported to develop and maintain relationships with people that matter to them, both within the service and the wider community to avoid social isolation.

The service does not have a nominated Dementia champion(s) to oversee standards in the service.

The Home has demonstrated achievement of this outcome.

Safe Care and Treatment

6 – Safeguarding

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, assessments have been undertaken to ensure safeguarding referrals are completed when incidents occur, appropriate investigations take place and the outcome is shared with the resident, families and advocates. A safeguarding log is maintained to ensure the home and professionals can track progress from start to finish including analysis of lessons learned.

The home continues to have a robust Whistle Blowing Policy and staff are aware of the escalation process should this be required.

Safeguarding trends have been analysed – see appendix 1 for further information.

Source *- QSF Report 21ST February 2024*

Safeguarding systems, processes and practices are in place, staff are aware and any updates are communicated to staff.
Systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect.
Staff can recognise signs of potential abuse and know what to do when abuse is suspected.
Processes are in place to ensure people are protected from discrimination, harassment and abuse, in line with the Equality Act.
People are supported to understand what safeguarding means, and they are encouraged to raise any concerns.
If people are subject to a safeguarding investigation, they are supported during this process.
Staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate.
There are processes for reviewing and investigating safeguarding incidents when incidents occur. All relevant staff, services, partner organisations and people who use services are involved in reviews and investigations.
Safeguarding investigations, reviews and audits ensure lessons can be learned to improve how care, treatment and support is delivered.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

7 – Medication

Outcome Assessed – Fully Met

It is vitally important that the service ensures the Council are fully informed of all medication incidents and near misses. It is mandated by the Teeswide Safeguarding Adults Board that Councils collect this information from all regulated services. The Council therefore requires homes to provide a monthly schedule of incidents or a statement of “nil return”.

The service has complied with this requirement having submitted information on 9 occasions in the last 12 months.

The medication outcome has been assessed by the Medicines Optimisation Service further information can be found in the Assessment Report dated 03-Dec-2025 appended to this report.

The home scored highly in their audit but some minor areas have been identified for improvement and the home must work towards the action plan set by the Medicines optimisation team.

8 – Cleanliness & Infection Control

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, evidence has been provided to confirm the home has completed Infection Control Workbooks regularly and has appointed an Infection Control Champion who has undertaken a training course with the Infection Prevention Control Service from the University Hospital of Hartlepool & North Tees to ensure they fully understand the remit of the role. The service has completed a self assessment of their work practices and scored 100% although this has not been verified.

Source *- QSF Report 21st February 2024*

There are arrangements for making sure that premises are kept clean and hygienic so that people are protected from infections that could affect both staff and people using services. This includes:- Up to date Policy and procedure- Staff Training, including with the IPC Nurses- Necessary resources- Risk Assessments- Cleaning Records/Schedules- Quality Audits
Staff understand their roles and responsibilities in relation to infection control and hygiene and providers support with this.
Policies and procedures are maintained and followed in line with current relevant national guidance.
The service ensures that it alerts the right external agencies (e.g. HBC, visitors, and professionals) to concerns around infections that affect people's health and wellbeing.
The Service completes regular Hand Hygiene documentation and has a designated IPC Champion who has attended the IPC Study Day. The Service has up to date IPC workbook/training.
The Service provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
The Service engages with and updates the Infection Control Nurses when required.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

9 - Premises & Equipment

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Source *- QSF Report 21ST February 2024*

Technology is used to support people to receive timely care and support and is easy to use.
Equipment, which is owned or used by the provider, is managed to support people to stay safe.
The premises and safety of communal and personal spaces (such as bedrooms) and the living environment are checked and managed to support people to stay safe.
Learning from lessons is shared and themes are identified to make sure that action is taken to improve safety across relevant parts of the service. Staff learn from reviews and investigations by other services and organisations.
The service has arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations and reviews. Information is shared to staff when appropriate.
People are involved in decisions about the environment. Any changes to the environment are managed to avoid causing distress to people who live there.
People have access to appropriate spaces: • in gardens and other outdoor spaces• to see and look after their visitors • for meaningful activities • to spend time together • to be alone.
The signage, decoration and other adaptations to the premises generally help to meet people's needs and promote their independence. However, some areas of the home would not benefit from an update.
Any specialist equipment such as the stairlift is maintained by an external company. No one currently living at Seymour House requires hoist transfer.
There are plans for responding to emergencies or untoward events, and these are understood by all staff.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

10 - Health & Safety

It has not been possible to complete the Health & Safety Assessment and verification this year. The Council will continue to develop the process for further assessment outside of the Quality Standards Framework.

11 – Moving & Handling

The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

The service has evidenced it works in partnership with the HBC Falls Prevention Team to analyse trends in falls within the home and to identify preventative measures to protect residents where possible.

Source *- QSF Report 21ST February 2024*

There is an up to date Moving and Handling Policy in place.
People who use the service are assessed in relation to their mobility needs and referrals are made to specialist agencies in a timely manner if required.
The service ensures that risk assessments are robust and appropriate.
Professional instruction/task guidance are detailed in people's support plans if required.
No people currently living within the service require assistance with transfers.
Some of the more elderly residents living within the service are offered reassurance with mobility when needed in a compassionate manner by staff.
The majority of staff last received Moving & Handling Training in January 2022 and would therefore benefit from refresher training.
No equipment is currently used specifically for the purpose of moving & handling.
There has been no near misses or accidents whilst hoisting in the last 12 months.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

Governance

Outcome 12 - Leadership & Management

Determination - Fully Met

There is a registered manager in post.

There are arrangements including within the rotas, for making sure that staffing levels are sufficient, staff have the right mix of skills, competencies, qualifications, experience and knowledge, to meet people's individual needs and personal preferences are accounted for where possible.

Managers are aware of the day-to-day culture in the service including the attitudes, values and behaviour of staff. They encourage staff to feel positive and proud to work in the organisation

The service promotes and supports fairness, transparency and an open culture for staff.

The manager makes sure that staff are supported, respected and valued. Their rights and wellbeing are protected and they are motivated, and caring.

The service shows honesty and transparency from all levels of staff and leadership following an incident. This is shared with people using the service and their families in line with the duty of candour. The service ensures people are supported when incidents occur.

Leaders have the skills, knowledge, experience and integrity they need to lead and inspire staff effectively. There is an open door policy in place and staff are able to

The service has a clear vision and set of values and leaders make sure that these are promoted and understood by staff and embedded into practice.

The organisation promotes equality and inclusion within its workforce and all staff have up to date equality and diversity training.

All relevant legal requirements are understood and met, including CQC registration requirements, safety and public health related obligations, and the submission of notifications.

Staff are actively involved in developing the service.

The home does not have any formal links with the local community; however, it is situated on the seafront. Local residents engage positively with people living in the home, and residents frequently access the community independently.

The service works in partnership with key organisations, including the local authority, safeguarding teams and Integrated Care Boards and multidisciplinary teams, to support care provision, service development and joined-up care and does so in an open, honest and transparent way.

The service has clear disciplinary procedures which are followed when it identifies that staff are responsible for unsafe practice.

The Home has demonstrated achievement of this outcome.

Outcome 13 - Staffing, Recruitment, Support & Learning

Determination - Fully Met

All staff have received appropriate induction upon commencement of employment.

Staff receive effective training in safety systems, processes and practices and this is reviewed regularly.

Staff receive feedback from managers in a constructive and motivating way, which enables them to know what action they need to take.

The service makes sure that responsibility and accountability is understood at all levels with clear and transparent processes in place for staff to account for their decisions, actions, behaviours and performance.

Staff are supported and protected when raising concerns and questioning practice including whistle-blowers.

Safety is promoted in recruitment practices, arrangements to support staff, training arrangements, disciplinary procedures and observations.

Staff respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort or emotional distress.

People have their assessed needs, preferences and choices met by staff with the right qualifications, skills, knowledge and experience.

Staff are supported to keep their professional practice and knowledge updated in line with best practice.

Staff know and understand what is expected of them and this is reinforced with regular support, supervision, appraisal and training.

Staff teams work collaboratively, share responsibility and resolve conflict quickly and constructively. There are cooperative, supportive and appreciative relationships among staff.

There are effective systems of communication to ensure information is shared timely and appropriately so staff can carry out their roles and responsibilities effectively.

The service gives staff the time, training and support they need to provide care and support in a compassionate and personal way. Staff have time to listen to people, answer their questions, provide information and involve people in decisions

The Home has demonstrated achievement of this outcome.

Outcome 14 - Quality Assurance

Determination - Fully Met

The service maintains a log of whistleblowing, staff concerns, safeguarding and accidents or incidents and investigates each incident thoroughly. Action plans are developed and monitored to ensure actions are completed.

A Formal Lessons Learnt process is not in place but the home has proven that they respond appropriately to incidents and analyse and adapt practices accordingly.

The service ensures that its approach to quality is integral and all staff are aware of potential risks that may compromise quality.

The service enables and encourages accessible open communication with residents and staff but would benefit from more proactively seeking the views of other stakeholders such as family, friends or visiting professionals.

Some people's views and experiences are gathered but this is generally from residents and staff. Further work to ensure all stakeholder feedback is sought as well as more robust evidence showing how this has improved the service and culture.

Resources and support is available to develop staff and teams and drive improvement, examples of these were provided by the manager.

Quality assurance systems generally enable the service to evaluate and learn from current performance ensuring continuous improvement and to improve future performance.

Success and innovation is recognised, encouraged and implemented The home has recently made changes to the appraisal system for the RMNs which will recognise their achievement and reward appropriately

The service ensures that the delivery of care, treatment and support is inline with current local and national guidance.

The provider is accredited as standards are met or approaching standards in the DPST Toolkit.

Quality monitoring process are in place but the service would benefit from a more robust analysis process to look for trends.

The level of impact has been assessed as low – there is no or minimal impact on residents.

The likelihood that the impact will happen or recur has been assessed as unlikely – the impact will probably never happen/recur as there are control measures and processes in place.

The Home has not demonstrated achievement of this outcome.

15 – Complaints

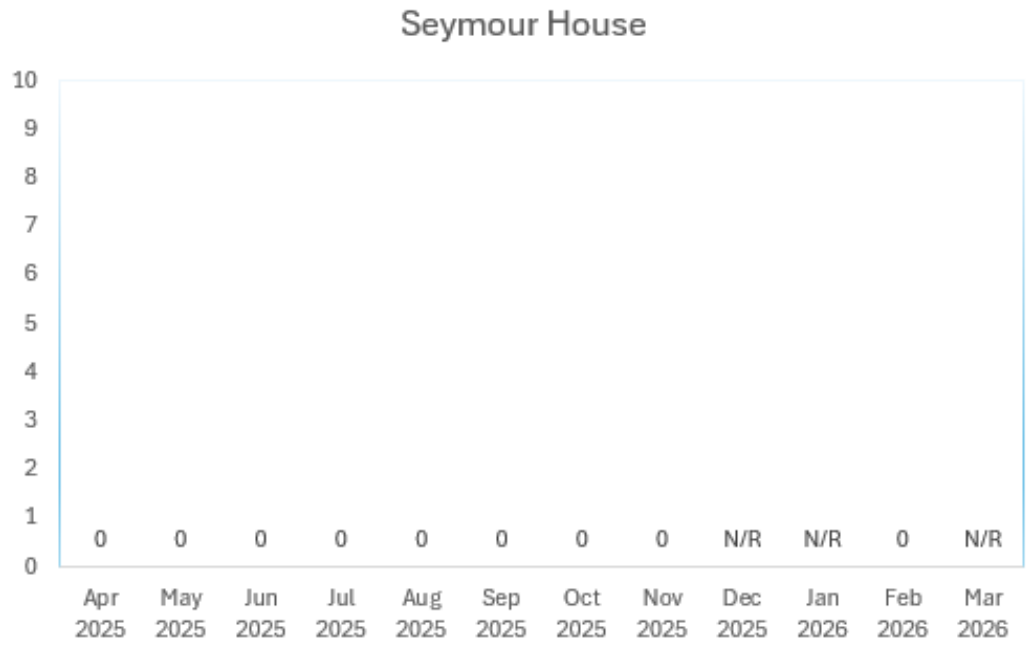
The findings below are from the Quality Standards Framework Report for Seymour House dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Source *- QSF Report 21ST February 2024*

People who use the service are provided with information on how to make a complaint or raise concerns and this is regularly promoted.
The complaints process is accessible, is easy for people to raise a concern or complaint and is encouraged.
There is a formal log of complaints which is kept up to date. Complaints are handled effectively with openness, transparency and confidentiality.
However, the service would benefit from more a robust analysis process to look for common themes and trends and to ensure lessons are learned.
People who raise concerns or complaints are protected from discrimination, harassment or disadvantage and are supported throughout the process.
Concerns and complaints are used as an opportunity to learn and promote continuous improvement and examples of this were evidenced.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

Appendix 1


Seymour House
10
9
8
7
6
5
4
3
2
1
0
0
0
0
0
0
0
0
0
N/R
N/R
0
N/R
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025
Sep 2025
Oct 2025
Nov 2025
Dec 2025
Jan 2026
Feb 2026
Mar 2026