

Seaway Nursing Home Limited

Seaway Nursing Home

Inspection report

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East Sussex
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13 March 2018

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 12 and 13 March 2018. The first day of the inspection was unannounced, on the second day the registered manager, area manager, staff and people knew to expect us. Seaway Nursing 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.

Seaway Nursing Home is situated in Hove, East Sussex and is one of two homes owned by the provider, Seaway Nursing Homes Limited. Seaway Nursing Home is registered to accommodate 20 people. At the time of the inspection there were 16 people accommodated in one adapted building, over three floors. Each person had their own room and had access to communal bathrooms, lounge and gardens,

The home had a registered manager. A registered manager is a '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 management team consisted of the registered manager and an area manager who was based at the home.

At the previous inspection on 22 February 2017 the home received a rating of 'Requires Improvement' and was found to be in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to complete an action plan to inform us of what they would do and by when to improve the key questions of Safe, Effective and Well-led. At this inspection we continued to have concerns. The overall rating for this service is now 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Staff had an understanding of safeguarding adults; however, it was not evident if systems and processes considered people's safeguarding if they experienced an unexplained injury. There was an over-reliance on restrictive practices to manage people's needs and behaviour. Appropriate procedures had not always been followed to ensure that these were in compliance with legal requirements. Risks to people's safety had not always been managed and guidance provided by external healthcare professionals had not always been implemented to ensure people received safe care and treatment. These were areas of concern. As a result three safeguarding referrals were made to the local authority by CQC following the inspection.

There was mixed feedback in relation to staffing levels and observations raised concerns with regards to the practices used by staff to meet people's needs. This was an area of concern.

People were not always supported in a person-centred way and their dignity and privacy was not always respected. The environment did not provide people with opportunities to socialise or interact with one another. Some people, particularly those who were less independent, spent large amounts of time with very little stimulation or interaction with staff, other than when providing support to meet their basic care needs. People were at risk of social isolation, although a dedicated activities coordinator took time to interact and engage with people, there were concerns about the lack of stimulation when they were not working. These were all areas of concern.

There was a lack of oversight of the home from both the registered and area manager. Quality assurance processes were not always effective. When audits had been conducted shortfalls had not always been identified. The registered manager and provider had not consistently monitored the systems and processes within the home to ensure that they were meeting people's needs and to continually improve the service. The registered manager and provider had not always submitted notifications to CQC to inform us of incidents and events that had occurred at the home to ensure that appropriate action had been taken. Records did not always contain sufficient detail and were not always completed. It was not always evident if people had received appropriate care or if staff had failed to update the records. The leadership and management of the home was an area of concern.

Areas in need of improvement related to guidance to inform staff's practice on the administration of 'as and when required' medicines and the need to adhere to organisational policies in relation to recruitment practices.

People and a relative told us that staff were kind, caring and compassionate and our observations confirmed this. One person told us, "Staff are very good, kind and patient". A relative told us, "The care is as good as it can be". People told us that they felt safe, comments included, "Staff are always looking out for me when I move about" and "Yes, I am safe here". People received their medicines on time and there were safe systems in place for the ordering, storage and disposal of medicines. Most risks in relation to people's care had been assessed and managed and practice changed as a result. People were protected by the prevention and control of infection.

People received support from external healthcare services when required and told us that they had faith in staff's abilities to notice when they were unwell. People were able to share their views and opinions through annual surveys and bi-annual residents' meeting. The provider had a complaints policy and people told us that they felt able to raise concerns and complaints without fear of repercussions. Staff were trained and competent and supported people in accordance with their needs and preferences. People received good end of life care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

read what action we told the registered manager 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?

Inadequate ●

The home was not safe.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow. However this had not always been followed consistently. Some people were subjected to unauthorised restrictive practices and there were concerns regarding people's safety.

There was insufficient staff to meet people's needs.

Medicines were administered on time and medicines management was safe. People were protected from the spread of infection.

Is the service effective?

Requires Improvement ●

The home was not consistently effective.

People were asked their consent before being supported. However, the provider had not consistently worked in accordance with legislative requirements.

People did not have a positive dining experience. People had access to healthcare services to maintain their health and well-being. Although guidance provided by healthcare professionals had not always been adhered to.

People were cared for by staff that had received training and had the skills to meet their needs.

Is the service caring?

Requires Improvement ●

The home was not consistently caring.

Interactions and staff's response to people's needs did not always demonstrate a respectful or caring approach to people's privacy and dignity.

Independence was not always promoted to encourage people's self-esteem and develop and retain their skills.

People were able to make their feelings and needs known and were supported to access external support if they needed assistance to make decisions about their care and treatment.

Is the service responsive?

The home was not consistently responsive.

Not all people had access to activities and stimulation. People were not always supported to engage in meaningful activities and were at times, at risk of social isolation.

People were not always supported in a person-centred way.

People and their relatives were made aware of their right to complain. People were encouraged to make comments and provide feedback to improve the service provided.

People were supported to have a pain-free and comfortable death.

Requires Improvement ●

Is the service well-led?

The home was not well-led.

Quality assurance processes did not always ensure that the delivery of care met people's needs and did not drive improvement. CQC had not always been notified of incidents or events that had occurred at the home.

There was mixed feedback about the leadership and management of the home.

Records to document the care that people received were not always completed. It was unclear if people had received appropriate care or if staff had failed to record their actions.

Inadequate ●

Seaway Nursing 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 12 and 13 March 2018. The first day of the inspection was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience had experience of older people's services. On the second day of the inspection the registered manager, area manager, staff and people knew to expect us. The inspection team consisted of three inspectors.

Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications and an action plan that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). 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 eight people, one relative, three members of staff, the area manager and the registered manager. Prior to the inspection we contacted the local authority for their feedback. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for nine people, medicine administration records (MAR), six staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounge and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

The home was last inspected on 22 February 2017; the home was rated as 'Requires Improvement'.

Is the service safe?

Our findings

At the previous inspection on 22 February 2017, the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of safe recruitment practices. In addition, an area in need of improvement related to the lack of guidance for staff for 'as and when' required medicines. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure improvements were made. At this inspection some improvements had been made and the provider was no longer in breach of Regulation 19. However, not all the shortfalls had been addressed and we found other areas of practice that required improvement.

Staff had an understanding of safeguarding adults; they had undertaken relevant training and could identify different types of abuse. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. The provider and management team had worked with the local authority when they had undertaken safeguarding enquiries. In addition, records showed that the registered manager had sometimes raised safeguarding alerts to the local authority when they were concerned about people's well-being. However, we found that this was not always consistent. Accidents and incidents that had occurred had been recorded and monitored. Records showed that one person had an unexplained bruise to their eye. Incident and accident records had been completed and a photograph of the bruise was taken. In addition, staff had consulted with the person's GP. However, it was not evident what action had been taken to identify the cause of the bruise. When this was raised with the registered manager they explained that the incident had occurred whilst they were on leave and that it had been dealt with by the area manager. Records showed that the area manager had reviewed the accident and felt that the person may have accidentally bumped their eye whilst in their room. The person had a condition that affected their ability to fully communicate their needs and due to their condition would be classed as a vulnerable adult. However, it was not evident within the incident records if consideration had been made to report the incident to the local authority as a potential safeguarding alert. It was not apparent what procedures were in place to ensure that when incidents occurred there were appropriate systems to ensure people's safety. As a result CQC made a safeguarding referral to the local authority subsequent to the inspection.

Records for one person advised staff, 'Whilst in wheelchair keep waist belt on'. Observations of the person showed staff assisting them into the lounge using a mobilising wheelchair. When asked if the person was going to be supported to sit in an arm chair staff explained that the person would stay in the wheelchair, wearing their lap belt, as staff would not be in the lounge area for approximately 30 minutes as they needed to assist other people. Staff explained that when in the arm chair the person continually tried to stand and that the person was safer in their wheelchair. When asked what happened when the person did not use their wheelchair staff told us, "They will eat their lunch in the wheelchair and then return to bed afterwards". Staff then confirmed that the person had bed rails in place on their bed. Although staff were working to ensure the person's safety this raised concerns with regards to the use of unauthorised restrictive practices. As a result CQC made a safeguarding referral to the local authority subsequent to the inspection.

Records for another person stated, 'To stay in bed until their wheelchair is delivered'. When the registered manager was asked if the person had been in bed whilst waiting for their wheelchair to be delivered they told us that they had as the person became agitated and aggressive when in an arm chair. Observations showed that the person had a specialised wheelchair in their room, however was in bed, with bed rails in situ, for the duration of the two day inspection. Staff were asked why the person was not being supported to get out of bed and told us that the person became aggressive and agitated when in their chair. One member of staff told us, "They are out in their wheelchair once a week". The registered manager told us, "They are out of bed at least weekly. It depends if they want to get out of bed as they are not keen on being touched or moved". Records showed that an occupational therapist had recommended that the person sit out in the specialised wheelchair for two-three hours each day to assist the person with their strength and posture, however, had advised continual supervision as they could become agitated when using the chair. It was not evident that staff had offered the person the opportunity to get out of bed and into their specialised wheelchair. There were concerns that restrictive practices were being used to manage the person's behaviour. As a result CQC made a safeguarding referral to the local authority subsequent to the inspection.

The use of restraint to manage people's behaviour and the lack of action when a vulnerable person sustained an unexplained bruise are areas of concern. The registered manager had not always safeguarded people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had been assessed by a Speech and Language Therapist (SALT). Guidance for the person stated that they should be offered an empty spoon in-between each mouthful to assist the person to swallow food that was in their mouth. In addition, it advised that the person remain in an upright position after eating. Observations showed that the person was not supported to use a spoon in-between mouthfuls and was assisted to lay flat after they had finished their meal. The person was being supported to eat and drink by a member of staff who was not part of the care team. When the member of staff was asked about the SALT guidance, which was displayed on the person's wall, they explained that they did not know about it. They told us, "I didn't know about that. That is something I need to pay attention to". The registered manager had not ensured that the person was being supported by a member of staff who had the relevant skills, experience and competence to ensure that they were supported safely and in accordance with guidance provided by the SALT.

Records for the same person demonstrated that guidelines had been devised by an external healthcare professional. The guidelines advised that the person should be supported in their wheelchair frequently, that they should be tilted whilst using the chair and be supervised at all times. Records to document an accident that had occurred whilst the person was using the chair showed that the person had had an un-witnessed fall and had been found by a member of staff who was not part of the care team. The registered manager had reviewed the record that documented the accident, this stated, 'X is on 15 minutes checks, 24 hours a day. After conversations with staff it seems that X shuffled on the chair until they slid off. Staff instructed to monitor X often when they are in the wheelchair'. This raised concerns that the person had not been supervised at all times whilst using the wheelchair, as had been advised in the guidelines provided by the hospital.

Care and treatment must be provided in a safe way. The provider had not ensured that they were doing all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had been assessed and staffing levels were aligned to meet those needs. Observations showed that staff responded quickly to people's needs. However, feedback from most people was that there

was insufficient staff to meet their needs. Comments from people included, "Yes, I am safe but it can be hectic here", "They are short of staff", "I think they do need more staff", "They are always short of staff, call bell response is slow" and "I feel hurried in the morning like having a shower just before lunch". A comment within a recent staff survey echoed these comments and stated, 'We need one more member of staff during the day'. One member of staff told us, "We haven't got enough staff. Sometimes there are only two of us and we have just coped". Staffing throughout the day consisted of the registered manager, a registered nurse and three carers. In addition there was an activities coordinator and ancillary staff. The home was not at full capacity and we observed that people spent their time in their rooms and were encouraged to return to their rooms when they independently walked to the lounge. Our observations and conversations with staff identified some practices like the use of lap belts and bed rails were being used to meet people's needs and manage their behaviours due to not always having sufficient staff on duty.

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection an area of concern related to the lack of DBS checks to ensure that prospective staff were safe to work within the health and social care sector. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. In addition, some files did not contain appropriate identification or references from staff's previous employers and there were gaps in staff's employment histories. At this inspection prior to staff's employment commencing, information about their employment history as well as identity checks were undertaken. Documentation also confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC). There were further checks to ensure that temporary staff, who sometimes worked at the home, were suitable to work with vulnerable groups of people. The registered manager had obtained information from the agency that employed the temporary staff to assure themselves that suitable checks had been carried out. DBS checks had been obtained and the provider was no longer in breach of the regulation. However, we found that the provider was not always working in accordance with their organisational policy. This stated that two professional references should be obtained prior to staff starting work. Records showed that one member of staff only had one reference and that this had been provided by a former colleague. When this was raised with the registered manager they explained that there had been another reference, however there were unable to locate it. This is an area in need of improvement.

People were assisted to take their medicines by trained staff that had their competence assessed. Observations demonstrated that safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and appropriate guidance for staff. Most records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People told us that they were happy with the support received. Arrangements had been made for people's medicines to be reviewed to ensure that medicines to support people to manage their behaviour were monitored and their excessive use minimised. Appropriate documentation was in place so that information about people's medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital. People told us that they were happy with the support they received with medicines. One person told us, "I do get my medication when I expect them and they watch me take them".

At the previous inspection an area in need of improvement related to the guidance provided to staff when

people were prescribed 'as and when required' medicines. Some information for 'as and when' required medicines was contained on people's MARs. However, there were no 'as and when' required protocols. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'as and when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'as and when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'as and when required' medicines in people's care plans. Although the provider had a medicines policy staff were not provided with individual guidelines for people's 'as and when' required medicines. This was raised with staff who explained that they knew people well and were able to ask them if they required any 'as and when required' medicines or would discuss as a staff team and make a decision. Despite this being an area in need of improvement at the previous inspection staff were not provided with clear, recorded guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way. Therefore this continues to be an area in need of improvement.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People, when appropriate, were supported with their continence needs and had access to hand-washing facilities.

Risks associated with the safety of the environment and equipment were identified, yet not always managed or monitored appropriately. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency.

Is the service effective?

Our findings

At the previous inspection on 22 February 2017 an area in need of improvement related to staff's access to training to meet people's specific needs. At this inspection improvements had been made. People told us that they had confidence in staff's abilities. One person told us, "It seems they are good at what they do".

Staff were supported with their learning and development from the outset of their employment. New staff completed an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures, an orientation of the home and an awareness of the expectations of their roles. Staff were encouraged to complete courses which the provider considered essential and registered nurses were provided with access to courses to maintain their competence and to ensure their knowledge and skills were current.

Despite this improvement we found other areas of practice that were in need of improvement. People and their relatives told us that staff asked for people's consent before offering support. One person told us, "Staff do chat with me about everything to do with my care". 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. We checked whether the provider was working within the principles of the MCA. Although staff had received training there was a lack of understanding with regard to the MCA and its implementation and impact on people who lacked capacity to make certain decisions. Observations did not always show that staff explained their actions or gained people's consent before offering support.

Staff did not always adhere to the legal requirements associated with assessing people's capacity to make decisions and to gain their consent and there was an inconsistent approach to assessing capacity. Records for one person showed that they were living with dementia. To ensure their safety the person used bed rails whilst in bed and a lap belt whilst in their wheelchair. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails and lap belts for wheelchairs are implemented for people's safety but can restrict movement. When asked if the person had capacity and had consented to the use of these, the registered manager explained that the person did not have capacity. However, there was no documented evidence to show that the person's capacity had been formally assessed in relation to these specific decisions. Records showed that there had been conversations with the person's relative about the use of bed rails; however, they had wanted to seek further clarification. There was no documented best interests decision and the consent form for the use of bed rails and a lap belt had been signed by the registered manager.

Records for one person showed and staff confirmed, that they, as well as other people, had received a flu injection. Although the reasons for this were to ensure the person maintained good health, the person had a condition that could potentially affect their decision making ability. Staff had not first assessed the person's ability to consent to the injection and had not held a best interests discussion with the person's paid representative to ascertain if it was in the person's best interests for them to have the injection. When the issue of capacity to consent to the injection was raised with the registered manager they told us, "I suppose I

could think about that, although they are under a DoLS". This further demonstrated the inconsistent understanding around MCA and DoLS as the person's DoLS authorisation did not include the authorisation of the flu injection.

In accordance with the MCA, when people lack mental capacity to make 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 are called the Deprivation of Liberty Safeguards (DoLS). Some people had DoLS authorisations in place and the registered manager and staff had ensured that people were supported appropriately and in accordance with any DoLS conditions. Other people had DoLS applications made to the local authority. Some of the people were living with dementia-type symptoms or conditions that could potentially affect their ability to make certain decisions. Some people were constantly supervised by staff and staff told us that most people were not able to leave the home without being accompanied by staff due to issues related to their cognitive ability and safety. Staff had not considered that people might lack the capacity to safely access the local community without staff support and that restrictive practices such as the use of lap belts and bed rails were being used. They had not considered making DoLS applications to the local authority to ensure that people's capacity was assessed and any restrictions on people's freedom were authorised.

The inconsistent application of MCA and DoLS is an area of practice that requires improvement to ensure that appropriate procedures are followed to gain people's consent and ensure that any decisions made in people's best interests are in line with legal requirements. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and observations and records confirmed that they had access to external healthcare professionals. People and relatives told us that they were confident in staff's abilities to recognise when they were not well and to seek medical assistance. People received timely intervention from healthcare professionals. One person told us, "We get the medical help when we need it. They [staff] organise the chiropodist to visit and we see the GP". Care staff monitored people's health and recorded their observations. They liaised with health and social care professionals involved in their care if their health or support needs changed. People's needs had continued to be holistically assessed and care plans were based upon assessments of their needs and wishes. Records showed that care plans were regularly reviewed and updated to reflect the care people received.

There were concerns that recommendations and guidance provided by external healthcare professionals had not always been adhered to. For example, one person had been assessed by a speech and language therapist (SALT) who had advised that they should be assisted to drink from an open cup with no lids, spouts or straws to assist their swallowing abilities and maintain their independence. Observations showed the person drinking from a beaker with handles, lid and a straw. When one member of staff was asked why guidance from the SALT had not been implemented they told us, "To be honest I find that it works better with a straw. It is difficult with an open cup". This demonstrated that people were not supported in a person-centred way and were instead supported in a way that was convenient for staff.

The provider had not ensured that the care and treatment people received met their needs or was appropriate. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was mixed feedback about the food provided and was dependent on individual chefs. Comments from people included, "The food here is not for me", "As far as the food is concerned it could be better" and

"The food standards here have dropped, it was much better". However, others were happy with the food and told us that they were provided with choice and were able to change their mind. One person told us, "Meals can be good". When people required assistance to eat and drink, staff were respectful and supported people in a dignified way. Aids and adaptations were made available for people to use to enable them to remain independent and to take into consideration their cognitive and physical abilities.

People had their own rooms and observations showed that a majority of people spent their time in their rooms. There was limited communal space that could be used to meet people's social needs and to encourage interaction. There was a lounge area with armchairs and lap tables and a small table in the corner of the room. Observations throughout both days of the inspection showed that people rarely used the lounge area. When the registered manager was asked about an area that people could use to enjoy their meals, the registered manager explained that people either ate their meals in their rooms or on lap tables in the lounge. They explained that sometimes, during the summer months, people had enjoyed using the garden table and chairs on the patio area. The table in the lounge was not made available for people to use and was blocked-in with mobility aids. There were no chairs for people to use if they chose to eat their meals at the dining table.

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care providers provide an environment that is conducive to eating. The environment was not conducive to a social and relaxed meal time experience. Although some people could choose to have their meals in the lounge, using lap tables, this did not promote a social environment, prompt orientation or promote opportunities for people to interact and enjoy conversations whilst having their meals. When meals were served there were no condiments for people to season or flavour their food and it was not apparent that this was offered to people.

The Alzheimer's Society suggests that as dementia progresses eating can become difficult for some people. It states that, 'The environment plays an important part in the eating and drinking experience. A good mealtime experience can have a positive impact on the person's health and well-being'. Within the tips provided to carers, it states, 'Make the environment as appealing to the senses as possible. Familiar sights such as tablecloths, flowers and playing soothing music at mealtimes can all help'. The registered manager was asked about the poor dining experience that some people received, they not feel that this had an adverse effect on people's experience as people had never requested to eat elsewhere. The environment was not set up in such a way so as to enable people to choose to have their meals at the dining table and observations did not show that people had been offered the opportunity to have their meals anywhere other than their room or on lap tables in the lounge. Comments from people further confirmed these observations and concerns. One person told us, "Not much choice about where I eat, here in my room or in the garden in good weather". Another person told us, "I'd love to go to the dining room to eat". People's dining experience is an area of practice in need of improvement.

The provider had not ensured that the premises or equipment were suitable for the purpose for which they were being used. This was a breach of Regulation 15 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Regular staff meetings, shift handovers and a communication book were used to share information and update themselves with regards to changes in people's needs. Staff told us that they felt appropriately supported that they communicated daily with the registered manager and felt that they could approach them if they had any concerns. The registered manager conducted regular observations of staff's practice to ensure that their practice was in line with organisational policies and people's needs. Staff had access to training that the provider considered essential for their roles and registered nurses were provided with

opportunities to continually learn and develop their clinical skills.

Is the service caring?

Our findings

People told us that they were cared for by kind and considerate staff. Comments from people included, "The care here is okay. All the carers are nice" and "The staff are nice and friendly, the people that work here are good". A relative told us, "All of the staff's attitudes towards residents are good". A comment within a recent relatives' survey stated, "My relative has been looked after with the greatest amount of kindness, care and respect". However, despite these positive comments we found areas of practice that required improvement.

Most interactions with people were kind and caring. Observations showed some staff spending time with people engaging in conversations. However not all interactions that were observed were positive and staff did not always demonstrate a caring approach to people's needs and feelings. One person took a member of staff's hand and began to dance. The member of staff, who was not a member of the care team, took time to speak kindly to the person and dance with them. The person enjoyed this as they were seen to be smiling. When the member of staff explained to the person that they needed to attend to something within the home, a member of care staff took the person's arm and led them back to their room, with little explanation, interaction or consideration for the person's wishes. This did not demonstrate respect for the person and did not promote their social needs.

Another person had been supported to go to the lounge using a mobilising wheelchair. The person was showing signs of discomfort and when staff were asked if the person would be supported to transfer to an arm chair they stated that the person would stay in the wheelchair as it was almost lunchtime. Lunch was not due to be served for a further 50 minutes. A member of staff asked the person if they were comfortable and the person stated, 'Not really, no. I suppose I'll be alright'. Staff then left the person in the mobilising wheelchair to attend to other people.

People were not always treated in a person-centred way. The provider had not ensured that care and treatment was appropriate, met people's needs or reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information held about people was kept confidential. Records were stored in locked offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. One person told us, "Oh yes, staff do treat me with dignity". Observations of staff's interactions with people did not always demonstrate this. Observations showed that when staff supported people they did not always explain their actions or involve people in the support that was being provided. Some staff were observed entering a person's room to have discussions with other care staff about the tasks they needed to complete. There was no acknowledgement of the person. The language staff used was not always respectful. For example, one member of staff was overheard saying, "Let's go and do number 5", whilst another member of staff was overheard saying, "I have finished my singles now, I'm bored and I have nothing to do". Observations for another person showed a member of staff entering their room, without knocking on their door and changing the channel on the person's television as it was playing loud music. There was no interaction with the person and the member of staff did not ask if this is what the person wanted to happen. Another person was assisted to transfer from their wheelchair to an arm chair in the

lounge using a hoist. Staff did not explain their actions or involve the person in the manoeuvre and whilst using the hoist staff did not notice that the person's undergarments were on display.

These interactions did not demonstrate respect for people's privacy and people were not always provided with dignified care. This was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's diversity was respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. A majority of people spent their time in their rooms, some due to their health conditions and associated nursing needs and others who either chose to spend time in their room or were encouraged to do so. It was not always evident how people were supported to be independent. One person told us, "In a way I am encouraged to be as independent as I can be". Observations showed one person accessing the outside space using their wheelchair, whilst others were observed independently walking around their rooms or areas in the immediate vicinity. When people attempted to walk from their rooms into the lounge, staff redirected them back into their rooms. The promotion of independence to encourage self-esteem and to develop and retain people's skills is an area of practice in need of improvement.

People and their relatives were involved in the development of their care plans. Although it was not evident how people were involved or contributed to the on-going review of their care, they told us that they were able to approach staff to air their views and that they felt listened to. Information about people's life histories, preferences, hobbies and interests was documented to inform staff and observations of staff's interaction demonstrated that they knew people's likes and dislikes well. People spent most of their time in their own rooms and a dedicated activities coordinator took time to visit people to interact and talk with them. People were encouraged and able to keep in contact with their family and friends. Visitors were welcomed in the home and visits were not restricted. One person told us, "There are no restrictions on visitors, they can and do visit". People's wishes, with regards to their preferences of male or female care staff, were ascertained and respected. Staffing allocation ensured that there were staff of different genders so that people's wishes could be respected and accommodated.

People were provided with support and sign posted to external organisations that they could access if they required further support to be involved in making decisions about their care, such as the local authority and their paid representatives which had been appointed as part of their DoLS authorisations. An advocate or a paid representative is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Regular surveys were sent to people and relatives to enable them to share their ideas and provide feedback on the care people received. Meetings where people could be kept informed of changes at the home were conducted during bi-annual social events.

Is the service responsive?

Our findings

People's health and physical needs were assessed and care plans documented people's choices and preferences. When asked if they felt that their needs were met, comments from people included, "I do get what I need" and "Yes, I do get all the help I need". However, despite these positive aspects, we found areas of practice that required improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. The provider had a statement of purpose that stated, 'To provide individual and group facilities and activities. To promote service user's to maintain their talents and capabilities'. This was not always implemented in practice. There was an activities coordinator who worked during the week and observations, records and people's comments showed that people had access to interaction and stimulation when the member of staff was working. People spoke fondly of the interactions they had with the member of staff and observations showed that the member of staff took time to go to people's rooms, have conversations, read books and newspapers and spend time with people. It was not evident what stimulation and interaction people were provided with when the activities coordinator was not at work and as there was only one member of staff responsible for activities, not all people had access to stimulation and interaction. When the member of staff was asked what activities or stimulation happened when they were not working, they told us, "Activities at the weekend...I'm not sure, you would have to ask the staff".

The Alzheimer's Society states that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Records showed and staff and people confirmed that people sometimes took part in activities such as bingo, quizzes and Bowles. In addition, external entertainers such as singers and Pet Pals visited the home. There were plans to support a person to attend a music concert. These activities were not provided to people regularly and observations showed and people confirmed that they spent most of their time in their rooms in armchairs or beds sleeping or with little to do to occupy their time. There was a lack of meaningful activities for people when the activities coordinator was not working or was with other people in their rooms. We observed staff being task-focused and they did not spend time with people to ensure that their social needs were met. As a result people were, at times, at risk of social isolation.

The home had a communal lounge, observations showed that a majority of people did not use the space and that only two people, during the course of the inspection days, were seen to be encouraged to use it. When three people attempted to go into the lounge independently staff were observed supporting them to go back to their rooms. This did not create a sociable environment and this, coupled with there being no dining room for people to use, meant that most people spent their days on their own in their rooms. It was not evident that the registered manager had identified or assessed the risk that this posed. When this was raised with the registered manager they told us that people wanted to stay in their rooms and did not ask to go into the communal lounge. One person told us that they were not sure if they could ask to be anywhere other than their room. This was raised with staff who asked the person if they would like to sit in the garden, the person did and was then offered support from staff. Some other people shared these views. One person

told us, "Not enough activities". Another person told us, "No to activities, I don't get out of my room". A third person told us, "I'd like to get out of my room sometimes".

There was mixed feedback from people about their involvement in decisions that affected their care. One person told us, "I have a care plan but I have not had any input". Other feedback was more positive. One relative told us, "I feel I am involved with decisions about my relative's care". People's physical health was assessed prior to, as well as when they moved into the home. Most people's care plans had a number of risk assessments which were specific to their healthcare needs. Most people's care needs had been assessed, planned and implemented to ensure that people maintained good health. People's risk of malnutrition was assessed; a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk. In addition, people's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. One person, who had been assessed as being at greater risk of developing pressure wounds, had been assessed by an external occupational therapist (OT) and had been provided with guidance. Part of the guidance related to supporting the person to use pillows to support certain areas of their body whilst lying in bed. Observations showed that this had not been implemented in practice. Records of the person's discharge from hospital showed that they had used an air mattress to reduce pressure damage to their skin. Observations showed that the person used a foam mattress. When the registered manager was asked why the person did not have an air mattress and was not being supported to follow the advice and guidance from the OT, they explained that the person had been pulling at the pump and leads to the mattress. They told us, "We made a decision to take the mattress off. We did a risk assessment for them not having it and the reasons why". The registered manager was not able to provide any evidence to support how this decision had been made.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The provider had a policy about AIS. There were concerns that people's communication needs were not always known by staff and care records did not always provide detailed information about people's communication needs. Records for one person, when they had been transferred from another service, stated that the person was blind in one eye. There was mixed understanding from staff with regards to the person's communication needs and staff told us that the person would often become distressed and anxious when being supported with their personal care. When staff were asked if the person had any difficulties with their communication, in particular with their sight, staff provided mixed responses. Some staff thought the person had difficulties with sight in the opposite eye to that which was recorded in the care plan, whilst other staff did not know that the person had sight impairment. Interaction and communication records for the person, from the other service, clearly informed staff that the person could become very agitated when receiving support with their personal care needs and would require verbal and physical reassurance from staff whilst explaining what was happening. However, this information had not been transferred to the person's care plan and staff did not appear to have considered that there could be a potential link to the person's impaired sight and their anxiety when receiving support with moving and positioning and their personal care needs. Staff were not always aware of the potential implications of the person's sight on their levels of anxiety and distress and had informed us that the person demonstrated behaviours that challenged. Staff had not followed guidance provided by external healthcare professionals so as to minimise the person's anxiety and distress when being supported.

Observations demonstrated that there was a service-led approach to people's care and staff did not always ensure that person-centred care was promoted. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were informed of their right to make a complaint. Surveys that were sent to people to gain their feedback provided an opportunity for people to raise concerns about their care. Most people told us that they had not had cause to make a complaint but were aware of how to do this and would not worry about any repercussions to their care.

People were encouraged and able to maintain relationships that were important to them. People were able to have visitors and told us that they were made to feel welcome and our observations confirmed this. Most people were provided with a call bell so that they could call for assistance from staff and told us that when they used their call bells staff responded promptly. For people who were unable to use a call bell, due to their capacity and understanding, regular checks were undertaken whilst people were in their rooms to ensure their safety.

Some people had planned for their end of life care and had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. The provider took precautions to ensure that they were prepared for people's conditions deteriorating. Staff received support and advice from external healthcare professionals to ensure people experienced a comfortable and pain-free death. Equipment had been hired and anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. Relatives were welcome and able to spend time with people at the end of their lives.

Is the service well-led?

Our findings

At the previous inspection on 22 February 2017, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of management oversight, the failure to act on known concerns in relation to staff recruitment and training and the analysis of accidents and incidents that had occurred. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure improvements were made. At this inspection some improvements had been made. However, there were continued concerns with regards to the managerial oversight of the home, staff recruitment and action taken when accidents had occurred. As a result the provider was found to be in continued breach of the Regulation. In addition, the registered manager had not always notified us of events and incidents that had occurred to enable us to have oversight that appropriate actions had been taken to ensure people's safety.

Seaway Nursing Home is one of two homes owned by the provider, Seaway Nursing Homes Limited. The management team consisted of a registered manager and an area manager. The provider had a statement of purpose which stated, 'We place the rights of the service user at the forefront of our philosophy of care and we seek to advance these rights in all aspects of the environment and the service we provide, to encourage our service users to exercise these rights to the full'. We did not always see this being implemented in practice.

The home was busy and we observed that most staff were task-focused. Most people were observed to spend their time in their rooms rather than be encouraged and able to use the communal lounge. Dining facilities did not support people to be able to enjoy their meals together. Some people told us that they would like to spend time outside of their rooms. Observations showed people looked bored and were either sleeping or spent their time unengaged and not stimulated. There was a lack of opportunity for positive interaction with other people. There was mixed feedback from people about the home. Most people were happy. One person told us, "Overall I am reasonably happy". Another person told us, "Happy here". Whilst a third person told us, "The service here has gone down over the past few years"; generally the care could be a bit better at my age". Questionnaires had been sent to staff to gain their feedback about the service. One comment stated, 'I feel that with some changes the home could be better and staff may be more motivated and residents more comfortable'.

A quality management system was in place and audits were conducted by the registered manager. Records of audits showed that shortfalls, such as those found during the inspection, had not been recognised. This related to the lack of detail in records, recruitment policies not always being adhered to, insufficient action taken to ensure people's safety, lack of guidance for people's 'as and when required' medicines, the use of restrictive practices and the inconsistent approach to MCA and DOLS. In addition, person-centred care was not always promoted. People did not always have access to stimulation and engagement and were at risk of social isolation. People's privacy and dignity were not always maintained and staff did not always implement external healthcare professionals' guidance.

There was insufficient oversight and action from the provider in relation to the running of the home. The

registered manager was still developing in their role and was yet to fully understand their role and responsibilities and this was evident within their answers to questions and their understanding of the requirements of the regulations. The provider had failed to oversee the running of the home during this time of transition and development and as a result the provider had not always ensured that they operated effective systems and processes to make sure they assessed and monitored their service against the regulations. The provider has a responsibility to ensure that this happens at all times, that they are responding to the changing needs of people and that the service is continuously improved.

Records showed that the area manager had made comments on certain documents to show that they had seen and were aware of the action that had been taken. However, there were no formal quality assurance processes undertaken by the provider to monitor the service. By not conducting these audits and by the registered manager not conducting rigorous audits, both the registered manager and provider did not have sufficient oversight.

Records, in relation to people's care and treatment, were not always consistently maintained. This related to food and fluid, bowel, repositioning, wound, medication and topical cream charts. Records were not always completed in their entirety and these incomplete records made it difficult to ascertain if people had received appropriate care or if staff had failed to complete the required records. For example, some people required their fluid levels to be monitored to ensure that they were receiving sufficient fluids to maintain their health. However, records showed that these had not always been completed in their entirety, did not contain information on the person's optimum daily fluid levels and had not been totalled. This meant that staff were not provided with guidance as to how much the person should aim to consume each day and were therefore not made aware of when they should report concerns with regards to a person's fluid intake. There was a lack of information and detail in people's care records. When records of people's care were not completed sufficiently or appropriately monitored there was a potential risk that any changes in people's conditions may not have been recognised.

On the first day of the inspection a request was made to view the electrical installation certificate for the building. Neither the registered or area manager were able to locate this and informed us that this had not yet been received from the electrician. On the second day of inspection the registered manager had still not obtained a copy and was asked to produce this within 48 hours of the inspection, however, this was not received in a timely manner.

When the concerns and areas in need of improvement were fed back to the registered manager throughout and at the end of the inspection, they did not demonstrate an openness to outcomes of the inspection. Nor did they acknowledge areas for service development or improvement to continually improve the service. There was a lack of openness, transparency and accountability from the registered manager and a culture of blame existed. The registered manager and provider were not ensuring that they were delivering the service people had a right to expect and had not ensured that the service continually improved. They had failed to assess, monitor and improve the quality and safety of the services provided, including the experiences of people in receiving those services. The home has been rated as 'Requires Improvement' at the two previous inspections. There remains concerns regarding the overall ability to maintain standards and to continually improve the quality of care.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always aware of their responsibility to comply with the CQC registration requirements. They had not always notified us of certain events that had occurred within the home so that we could have

an awareness and oversight of these to ensure that appropriate actions had been taken. These related to safeguarding enquiries that had been made by the local authority. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and is being dealt with outside of the inspection process.

People, relatives and staff had been asked to complete questionnaires to enable them to share their feedback about the running of the home and some comments people had been made had been acted upon, such as the redecoration of one person's room. There were other ways to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving through bi-annual residents' meetings that took place during social events. Records of meetings showed that people had been informed and updated of what was happening at the home. People and relatives told us and records confirmed that the provider and registered manager demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'.

The registered manager had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns. Staff told us that they were involved and kept informed of any changes within the organisation. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through regular meetings. The provider, management team and staff had made links with local external healthcare professionals, the local authority and other home managers to support staff to learn from other sources of expertise. Lessons had been learnt as a result of incidents, for example risk assessments had been implemented when risks had been identified as a result of people's lifestyle choices.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Regulation 18 (1) (2) (a) (b) of the Care Quality Commission (Registration) Regulations 2009. The registered person had not ensured that they notified the Commission without delay of incidents that had occurred when services were being provided in the carrying on of the regulated activity or as a consequence of carrying out the regulated activity.

The enforcement action we took:

A fixed penalty notice has been served on the provider for their failure to notify CQC of incidents and events that had occurred at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Regulation 10 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

The registered person had not ensured that service users were treated with dignity and respect.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 11(1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

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
Treatment of disease, disorder or injury	Regulation 13 (1) (2) (3) (4) (a) (b) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The registered person had not ensured that service users were protected from abuse and improper treatment.

Systems and processes were not established or operated effectively to prevent abuse of service users, investigate, immediately on becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Premises and equipment. The registered person had not ensured that the premises and equipment were suitable for the purpose for which they are being used.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (c) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Maintain securely such other records as are necessary to be kept in relation to each service user and persons employed in the carrying on of the regulated activity.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.
	The registered person had not ensured that there were:
	Sufficient numbers of suitably qualified, competent, skilled and experienced people
	That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.