Seaview Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Seaview Residential Home Limited 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.

The home accommodates up to 18 people and at the time of our inspection 12 people were living at the home. These people were all aged over 65 years and some were living with dementia. The service had two double bedrooms and 14 single bedrooms over three floors. There was a passenger lift so people could access each floor. Ten bedrooms had an en suite toilet with a wash hand basin and two bathing facilities were available to people. The home also had a main lounge, two smaller lounges, a conservatory and a separate dining room.

This inspection took place on 27 February and 7 March 2018 and was unannounced. The gap in the inspection dates was due to adverse weather conditions and the availability of key people.

At the time of the inspection there was not a registered manager in post at the service, there was a manager who had taken over the overall running of the service and was planning to apply to become registered to manage the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The laundry area was not properly maintained, in a poor state of repair, was unclean and cluttered. There was no process in place to prevent cross contamination between dirty items entering the laundry and clean items leaving the laundry. There were no records to show when the laundry room had last been cleaned and it was not a clean, hygienic or safe environment in which to launder people's clothes which increased the risk of cross infection.

Not all staff had up to date infection control training and infection control procedures were not robust and put people at risk of harm.

Where accidents, incidents, and near misses had occurred there was a process in place which recorded the incident. However, the information provided of the incident/accident or near miss was not always detailed and actions required to mitigate risks or prevent reoccurrence had not always been considered, followed up or implemented.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate

checks had been completed.

People received their medicines safely. Staff who administered medicines had received training and had their competency to administer medicines assessed to ensure their practice was safe.

Staff understood the need to gain people's consent to care and treatment. However, people's capacity to make decisions had not always been assessed in line with The Mental Capacity Act 2005.

People's needs were met by staff who were supported appropriately in their roles, however some staff refresher training in essential subjects was overdue.

People were supported to have enough to eat and drink and there was a choice of food which people told us they enjoyed eating.

Staff demonstrated an understanding of people's health care needs and people were supported to access healthcare services when required. There were clear procedures to help ensure people received consistent support when they moved between services.

Staff knew people well and demonstrated an in-depth knowledge of their individual needs. Staff developed caring and positive relationships with people and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were provided with appropriate mental and physical stimulation through a range of varied activities.

People's wishes and preferences for the care they wished to receive at the end of their life was clearly recorded which would, if provided, help to support people to have a comfortable, dignified and pain-free death.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs. People and their families were encouraged to provide feedback on the service provided both informally and through quality assurance questionnaires.

People and their families were able to complain or raise issues on a formal and informal basis with the manager and were confident these would be resolved. This contributed to an open culture within the home.

There were systems in place to monitor the quality and safety of the service provided. With the exception of the laundry area, the environment was well maintained and measures had been taken to adapt the environment to aim to meet the needs of people living at the home including those people living with dementia.

People and their families told us they felt the home was well-led and were positive about the manager who understood the responsibilities of their role.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were some systems in place to protect people from the risk of infection; however, we found the laundry area to be poorly maintained, unclean and cluttered, which increased the risk of cross infection.

The manager had assessed the risks associated with providing care to each individual. However, we noted one person's risk assessment and care plan had not been updated to reflect the person's change of need.

Where accidents, incidents, and near misses had occurred actions had not always been considered or implemented to mitigate risks.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Medicines were managed safely and people were supported to take the medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood the need to gain people's consent for care and treatment. However, we found that people's capacity to make decisions had not always been assessed in line with The Mental Capacity Act 2005.

People's needs were met by staff who were supported appropriately in their roles, however some staff refresher training in essential subjects was overdue.

People were supported to have enough to eat and drink and

there was a choice of food.

People were supported to access healthcare services.

There were clear procedures to help ensure people received consistent support when they moved between services.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

People were cared for with dignity and respect and all interactions between people and staff were positive and supportive.

People were encouraged to remain as independent as possible.

People were supported to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and demonstrated an in-depth knowledge of their individual needs.

People's wishes and preferences for the care they wished to receive at the end of their life was clearly recorded which would, if provided, help to support people to have a comfortable, dignified and pain-free death.

People were provided with a range of activities.

The manager and provider sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager used a number of audits to check the quality and safety of the service; however these were not always robust in

identifying concerns.

There was a clear management structure in place and staff understood the roles and responsibilities of each person within the team structure.

There was a positive and open culture and the manager and provider of the service had a robust oversight of this.

The manager and provider of the service actively sought feedback from people using the service and their families.

Seaview Residential Home Limited

Detailed findings

Background to this inspection

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

The inspection was unannounced and was carried out on 27 February and 7 March 2018 by an inspector, an inspection manager 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. The home was last inspected in August 2016 when it was rated as 'Good' overall with a breach of Regulation 15 of the Health and Social Care Act 2008.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with eight people who lived at the home and with four family members. We also spoke with the provider of the service, the manager, three care staff and the chef. We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We received feedback from one health care professional and one social care professional who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints,

accidents and incidents and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection, in August 2016 we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not ensured the premises were clean, fit for purpose and properly maintained to meet people's needs and ensure their safety. The provider wrote to us detailing the action they would take to meet the Regulation. At this inspection, we found some action had been taken. For example, bathing facilities were now available for people on the ground and first floors and both bathrooms had been refurbished and upgraded.

At this inspection we found that people were not protected from all risks of infection. For example, the laundry area was not properly maintained, in a poor state of repair and was unclean and cluttered. There was no process in place to prevent cross contamination between dirty items entering the laundry and clean items leaving the laundry. There were no records to show when the laundry room had last been cleaned and it was not a clean, hygienic or safe environment in which to launder people's clothes.

We observed plaster from the ceiling falling onto the clean laundry which was stacked on the shelves, the flooring under the washing machine and tumble drier was found to be torn and dirty; the condition of the flooring created traps where bacteria could breed and baskets which held people's laundered clothes were dirty. Additionally, there were exposed electrical wires; the room was cluttered with old equipment and the wash basin used by staff to wash their hands had a dirty urine bottle in it. The wash basin was also difficult for staff to access due to items being placed in front of it.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments were in place, and any staff training or outbreaks of infection that had occurred. Not all staff had up to date infection control training and infection control procedures were not robust and put people at risk of harm. Hand gel dispensers were situated throughout the home; on day one of the inspection a number of these were found to be empty. All the issues found in relation to infection control placed people at risk of infection. The concerns found were discussed with the manager and the provider of the service on day one of the inspection. On day two of the inspection we found that hand gel dispensers had been replenished. The manager and the provider of the service were also able to assure us that plans were now in place to address the concerns raised about the laundry room.

Following the inspection information was received from the provider which demonstrated that work to the laundry had been completed. This meant that the risk of cross contamination within this area had been reduced.

Other areas of the home were clean and well maintained. Protective equipment such as gloves and aprons were provided to staff to minimise the spread of infection and we saw that, when required, these were worn by staff.

The manager had assessed the risks associated with providing care to each individual. Each person's care file contained specific risk assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place included; choking, falls, medicines, safe use of the stairs and pressure sores. Risk assessments were reviewed monthly. However, we noted one person's risk assessment had been reviewed by the manager but the care plan and risk assessment had not been updated to highlight the person's change of need. This meant that the person may not have received safe and effective care as required. This was brought to the attention of the manager on day one of the inspection. By day two of the inspection we saw that all documentation in relation to this had been updated.

We found that where accidents, incidents, and near misses had occurred there was a process in place which recorded the incident. However, the information provided about the incident/accident or near miss was not always detailed and actions required to mitigate risks or prevent reoccurrence had not always been considered, followed up or implemented. For example, following a fall it had been identified that the cause of this may have been due to the person's footwear, however new footwear was not provided and two more falls occurred. Another person had an accident which resulted in skin damage. The cause of this accident had not been fully investigated and the record of this injury did not demonstrate that any recommendations had been made or actions taken to prevent future incidents. This meant that people continued to remain at risk of accidents, incidents and near misses. This was discussed with the manager who agreed to review the current process to ensure that lessons were learn and risks to people were mitigated.

The failure to prevent and control the risk of infection and to ensure risks to the health and safety of people were assessed and mitigated, were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their family members told us they felt that Seaview Residential Home Limited was a safe place. When people were asked if they felt safe their comments included, "Yes, there's plenty of staff around," "Oh yes. Due to the abilities of the staff" and "I do, I don't know why but I do." A family member told us, "It has put my mind at rest with [my relative] being here."

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. A staff member said, "If I had any concerns I would report them to my manager or the safeguarding team or CQC if I needed to." Records showed the manager had worked effectively with the local safeguarding team to undertake investigations and appropriate action had been taken to protect people from the risk of abuse.

Appropriate arrangements were in place to ensure that the staff were suitable to be employed at the service. Staff recruitment records for three members of staff showed the manager had operated a thorough recruitment procedure in line with their policy and procedure to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, records of interview and references. On viewing these records, we saw that any gaps in a staff member's employment history had been investigated and outcomes recorded. This meant that the manager was aware of what the staff members had been doing during these times and whether that impacted on their suitability for employment.

People and their families told us there were sufficient staff to meet people's needs. One person told us,

"There is plenty of staff around." Staffing levels in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. Staff we spoke with confirmed there were enough staff to provide appropriate care without being rushed in their duties. One staff member said, "At the moment we have enough staff", they also told us that in the past if the number of people living at the home increased the staffing levels had also increase.

The manager told us that staffing levels were based on the needs of the people using the service. They told us that they used a dependency tool to aid them to ensure that there were appropriate staffing levels in place and this was reviewed six monthly or more frequently if required. The manager said that as well as using the dependency tool, they listened to feedback from people and staff and observed care and the time it took staff to respond to the needs of people. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and agency staff. From viewing the duty rotas and observations, we saw that staffing levels were provided as required. The service also provided a cook each day as well as cleaning staff five days a week and a maintenance person. This ensured that care staff could focus their time on supporting people and their needs.

People told us that they received their medicines safely. A person said, "I get my medicine, they [staff] give it to me." During the inspection we saw that people were provided with their medicines in a safe and respectful way. Staff were heard asking people how they would like to take their medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken. When one person declined their medicines the staff member respected the person's decision, agreeing to return to them later.

Medicines were administered by staff that had received training and had their competency to administer medicines assessed by the manager or a senior staff member to ensure their practice was safe, this training was renewed annually.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR chart no gaps were identified, this indicated that people received their medicine appropriately.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines.

Environmental risks were assessed and managed appropriately. The manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment, moving and handling equipment and the monitoring of water temperatures.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans (PEEPs) had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they should take if an evacuation was necessary.

Requires Improvement

Is the service effective?

Our findings

People, their families, a healthcare professional and a social care professional told us they felt the service was effective. A family member told us, "[Person] is always clean and is well cared for. Since living at the home they are eating much better." A healthcare professional said, "I have no concerns at all, they [staff] think of the little things which makes a big difference to people, it's the personal touches." A social care professional told us, "The person I have come to see is being looked after really well, they have settled much better than I could have hoped."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that people's capacity to make decisions had not always been assessed in line with the MCA. For example, one person underwent a MCA assessment in 2012 with indicated that they had full mental capacity to make informed decisions. However; their care plan now stated, 'I can no longer retain information to make decisions' yet no formal capacity assessment had been completed to precede this statement. We also found that this person had been provided with the influenza vaccination. There was no written information as to why the vaccination was necessary or in the person's best interests. This meant the manager was unable to confirm that the decision made was done so in the person's best interest. In another person's care file, we saw that a capacity assessment had been completed appropriately and a best interest decision had been made which followed the principles of the MCA. The lack of understanding around the MCA was discussed with the manager who confirmed that this was an area they required more knowledge of. By the second day of the inspection the manager had sought additional training in this area.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. Staff were aware of the people that these restrictions applied to and the support they needed as a consequence.

People and their families told us that staff sought verbal consent before providing care or support, such as offering to provide support to help them mobilise or supporting with personal care. A person said, "I'm always asked." We observed staff seeking consent from people using simple questions and giving them time to respond. Staff told us how they offered choices and sought consent before providing care. One staff member said, "I wouldn't just do something, I would always ask the person first."

People and their families felt that the staff were well trained. One person said, "They [staff] are very good." A healthcare professional told us, "I have no concerns about the home or the abilities of the staff." The training staff had received included safeguarding, diet and nutrition, moving and handling, infection control and first

aid. In addition, some staff had completed other training relevant to their role, including diabetes, dementia and end of life care.

The manager had a system in place to record the training that staff had completed and to identify when training needed to be repeated. On reviewing this system, we saw that training had not always been updated in a timely way. For example, two staff members did not have up to date infection control training and one staff member's fire training had expired. This was discussed with the manager who told us they were in the process of reviewing the training records and arranging training where required. All the staff we spoke to felt that they received effective and appropriate training. Staff comments included, "We get loads of training" and "We do most of our training on line, which is fine. If I felt I needed any extra training I know this will be arranged by the manager."

Staff new to care were supported to complete training that met the standards of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. This helped the manager to ensure that staff understood and worked to expected standards of care.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training. Staff confirmed that they had received an induction when they started work at the service.

Staff were appropriately supported in their role. Staff confirmed that they received regular one-to-one sessions of supervision and a yearly appraisal with the manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. Staff said they felt able to approach the manager and provider of the service if they had any concerns or suggestions for the improvement of the service.

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. People and their families were complimentary about the food. When we asked people if they enjoyed their food their comments included, "It's good. I have a lot of curries as I have a problem with my swallowing", "Very good" and "It's very nice. I can eat it." People were provided with a choice of food and alternatives were offered if they did not want what was on the menu. During mealtimes, people were encouraged to move to dining tables although if they chose not to this was respected. This helped make the mealtime a pleasant and sociable experience. We observed lunch and saw that people had different meals according to their choice. Staff were supportive to people during meal times. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. When assistance was required, this was provided by staff in a relaxed and unhurried way.

People's nutritional needs were assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Care records showed referrals were made where people had nutritional or swallowing needs and the advice of the SALT was recorded. Staff were aware of which people needed soft or pureed food. Food and fluid intake was monitored where this was needed and people's weight was monitored so any action could be taken regarding weight loss or gain.

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. Additional healthcare support had been requested by the staff when required. For example, we saw that a

community nursing visit had been requested when staff were concerned about a person's skin and the continence team had been contacted in relation to concerns about another person's change in need. All appointments, visits and communication with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and information in relation to people's health needs and how these should be managed was clearly documented within people's care files.

We saw a range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate the person's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess a person's risk of developing pressure injuries and to monitor their bowel movements.

With the exception of the laundry area, the environment was well maintained and some measures had been taken to adapt the environment to aim to meet the needs of people living at the home including those people living with dementia. For example, signage and colour schemes were used to help people orientate themselves in the home. People living at the home were also being supported to make their own door signs which would enable them to easily identify their bedrooms. People had access to the gardens, which were safe, fully enclosed and provided various points of interest for people, including a mock fruit and vegetable shop, bus stop and train station based on historical designs. These were in place to assist those with dementia by providing a stimulating environment based on people's memory. People could freely move around the home and could choose from a number of different areas to spend their time. This meant that people were able to spend time alone or with others in an environment of their choosing.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. The manager told us that new services were provided with an up to date information form about the person and if required the person would be accompanied by a member of staff.

Good

Is the service caring?

Our findings

Staff had developed caring and positive relationships with people. People and their families told us that the staff were caring. When a person was asked if they felt the staff were caring they said, "Oh yes, they are wonderful." Family members comments included, "[My relative] is happy, safe and well looked after," "They [staff] are so friendly- all are absolutely lovely, I can't fault them," "There is a family atmosphere, everyone, staff and management treat residents as family" and "From the start the staff have been exceptional, both to residents and visitors." All the family members that were asked confirmed that they would be happy to recommend the home to others.

People were cared for with dignity and respect and all interactions we observed between people and staff were positive and supportive. Staff were heard speaking to people in a kind and caring way and would interact with people in a positive, friendly and cheerful manner. We saw staff kneeling down to people's eye level to communicate with them. We heard good-natured interactions between people and staff, showing they knew people well. Staff were observed to respond to people quickly when they showed signs of emotional distress. For example, during lunch a person became upset. This was immediately noticed by a staff member who asked them why they were upset and provided them with reassurance.

The manager told us they explored people's cultural and diversity needs by talking to them and their families and by getting to know them and their backgrounds. This information was then documented within the person's care file. The manager added that if a person followed a particular faith that they and the staff lacked knowledge of, they would research this by looking for information on the internet and speaking to followers of that faith to help ensure that people could be effectively supported.

People's privacy was respected when they were supported with personal care. During the inspection we heard a staff member say to a person who was sat in the lounge; "[Name of person] the nurse is here for your injection- shall we go to the bathroom." This was all done very discreetly to ensure the person's privacy was respected. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. A staff member told us, "We always make sure that we respect people's privacy."

Information regarding confidentiality, dignity and respect formed a key part of the induction training for all care staff. Confidential information, such as care records, were kept in a secure cupboard within the dining area or in the manager's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

People were encouraged to be as independent as possible. At meal times we saw that staff would encourage people to feed themselves and people had access to appropriate specialist equipment where required. We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their pace. Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example

one care plan stated, 'I am able to complete some tasks independently such as washing my hands and face, but I do need the staff to give me the flannel and clear prompts'. Staff understood the importance of maintaining people's independence and a staff member said, "We will encourage people to do things for themselves."

Where people had specific communication needs, these were recorded in their care plans and known to staff. We saw staff follow the guidance within people's care plans, including speaking clearly and giving people time to answer. The manager told us that picture cards were available to people where required to aid communication and written information was provided in large font when needed.

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and offered them choices in what they preferred to eat and where they wanted to spend their time. A staff member told us, "We always ask people what they want to do, it's up to them." A staff member was heard asking a person, "Would you like a bath this morning" and the persons response was respected.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who were important to the person. All of the families we spoke with confirmed that the manager and staff supported their loved ones to maintain their relationships. A person told us, "Oh yes my family visit a lot." The manager told us that there were no restrictions to visiting times and families could visit at any time. A family member said, "As relatives we are encouraged to come in at any time". They added, "The first thing I liked about this place was the wonderful reception we received on our very first visit." Another family member told us, "We are always made to feel welcome."

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "They look after us well." A second person told us, "I can get up when I choose." A family member said, "They do know [person] well." They added, "[Person] doesn't sleep well so they will always let them come downstairs at night and watch television." A healthcare professional told us, "I have no concerns at all; if I ask the staff to do something, like complete a fluid chart for a person I know this would always be done."

Each person had a care plan which contained individual information about their specific needs and how they wished them to be met. We viewed four care plans in detail and within three others we looked at specific areas only. We found that the information within one person's care plan was out of date, did not reflect the change in this person's needs and was not always detailed to ensure that consistent care could be provided. For example, in 2016 we saw that this person had made the decision to occupy a shared room to prevent social isolation. However, we found that they were now in a single room with no explanation as to why the decision had been made to move them and who had been involved in making this decision. The care plan still referred to this person sharing a room. Additionally, within this person's eating and drinking care plan it stated that a pureed diet was required; however, no other information was available to advise staff as to the consistency of the food. The risks posed by inaccurate and limited information in this care plan were mitigated by the relatively low turnover of staff and the fact that staff knew people well. When we spoke with staff they all demonstrated an extensive knowledge of people, including their current needs, wishes and preferences. The issues in relation with the person's care plan were discussed with the manager on day one of the inspection. By the second day of the inspection information had been reviewed and updated accordingly.

All other viewed care plans provided information to enable staff to give appropriate care in a consistent way. They were individualised and detailed people's preferences, likes and dislikes and how they wished to be cared for.

Staff kept records of the care and support they provided to people. For example, these records included 'turn charts' for people who needed support to reposition regularly and monitoring charts of the fluid input and output of people with catheters, to check they were working properly. These were viewed and we saw that they were well completed. This confirmed that people's needs had been met consistently.

Care and support was planned proactively and in partnership with the people using the service, their family members and healthcare professionals where appropriate. The manager completed assessments of the people before they moved to the home to ensure their needs could be appropriately met. Families told us that they were fully involved in the development and reviews of care plans and kept up to date about changes in their loved ones' wellbeing. A family member said, "Definitely (involved and kept up to date), after the recent fall I had a phone call telling me what had happened."

At the time of the inspection no one living at Seaview residential home was receiving end of life care. However, the manager was able to provide us with assurances that people would be supported to receive

good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Staff members had received training in end of life care and we found that the end of life wishes and preferences for people had been recorded within people's care records. This should help to ensure that people's wishes were respected and acted upon. The manager also told us that they would work closely with relevant healthcare professionals and provide support to people's families to help ensure that they were fully involved.

People were provided with appropriate mental and physical stimulation through a range of varied activities. The manager told us, "Activities are my big thing. When I first came here (October 2017), apart from entertainment that comes in, there wasn't much going on." The manager told us that there was now more focus on activities and a staff member was in place to provide activities for people. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. Activities included arts and crafts; including people decorating their own personalised mugs, cooking, cake decorating, reminiscence, games, music and armchair exercises. During day two of the inspection there was an outside entertainer in the home singing with people. The manager told us, "I'm trying to find activities that aren't patronising."

We saw people being encouraged to interact with others and staff sitting and engaging with them. One person showed us her painted nails and told us, "One of the girls (staff member) did them for me. I love them (nails)." During the inspection one person became restless so a staff member provided them with their 'favourite book'. A family member told us, "There is lots going on which [person] seems to enjoy; cake decorating and dominos." On viewing the minutes from the recent 'resident and relatives meeting', we saw that discussions had taken place which involved people in making decisions about future activities.

The manager sought feedback from people and their families on an informal basis when they met with them at the home, during telephone contact, email correspondence and during residents and relatives meetings. People and their families felt able to approach the manager at any time. Their comments included, "I am always kept up to date about what is going on" and "We can always talk to the manager when we want to." The manager and provider of the service also sought formal feedback through the use of quality assurance survey questionnaires sent annually to people and their families.

People and their families told us that they would feel comfortable raising concerns with the manager or provider of the service if they had any and were confident that any issues or concerns raised would be acted on. A family member said, "I feel I can approach the manager if I had a complaint." The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The manager told us they had received one complaint from a family member during the previous year. They explained the action they had taken to investigate the complaint and respond to the concern raised.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in place. The previous registered manager had left the service in October 2017. There was a manager in place who had taken over the overall running of the service, with support from the provider of the service. The manager told us they were going to commence the process to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Although there was no registered manager in place, there was still a clear management structure. This structure consisted of the provider of the service, the manager, a newly appointed head of care, senior care staff and care staff. Staff were able to describe the role each person played within this structure.

The manager used a number of audits to check the quality and safety of the service, however these were not always robust in identifying concerns. For example, the infection control audit completed by the manager in October 2017 had failed to identify the issues that were raised at the inspection. Within this completed audit the only concern noted in relation to the laundry was; 'very dusty behind machines'. Completed audits had also failed to highlight that some infection control training was out of date and infection control procedures were not robust and put people at risk of harm. Additionally, where accidents, incidents, and near misses had occurred the process in place to monitor these was not always detailed and ideas of how to mitigate risks or prevent reoccurrence had not always been considered, followed up or implemented. Care plan and risk assessments audits had not identified out of date information within one person's care record. This demonstrated that the concerns highlighted at the inspection had not been noted through the auditing process and action had not always been taken following completed audits.

Other quality assurance systems in place were effective. The manager carried out regular audits which included, health and safety and medicines management. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. Other formal quality assurance systems were in place, including seeking the views of people and their families about the service they received. Where issues or concerns were identified, an action plan was created and managed through the regular meeting processes.

People, family members, staff and professionals all described the service as well-led. A social care professional told us, "It's all very well organised." A healthcare professional said, "[Manager] is very proactive; they get things done." A staff member told us, "The manager is lovely, they are firm and fair". They added, "We can talk to the manager and owner any time. They listen to us, are supportive and value our opinions." Another staff member said, "I enjoy working here more so now that [manager] is in place, they are excellent. The owner is marvellous, a good boss; good to the staff and the residents."

The provider of the service and the manager were open to suggestions about how the service could improve. People, their family members and staff confirmed that they felt able to approach them with ideas,

which were taken seriously. The manager had updated their knowledge and understanding of some current care practices including safeguarding people, making adaptations to the environment to assist people who lived with dementia and safe management medicines. Where gaps in the manager's knowledge were identified during the inspection including; understanding of The Mental Capacity Act 2005 and acting on accidents, incidents and near misses this was acknowledged by the manager who took immediate action to improve their understand of these areas and implement more effective processes to prevent harm to people.

Observations and feedback from staff and family members showed the home had a positive and open culture. Staff and family members all told us they found the manager and provider of the service approachable, easy to talk to and felt that they were able to raise any concerns or issues which would be acted on. A family member said, "They always let me know what is going on." Another family member told us they would have, "no qualms at all" about raising any concerns with the provider of the service or manager. Staff confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed.

The provider of the service was fully engaged in the running of the service and had suitable arrangements in place to support the staff and the manager. The manager told us that the provider of the service was very supportive and visited the home approximately four times per week to ensure the effective running of the service and provide support to staff. The manager also told us that they provided a weekly update report to the provider of the service to notify them of any changes to people's needs, up to date information on staffing and any issues or concerns raised about the maintenance of the building.

The provider of the service told us, "The residents are my first priority; we need to give them the best. My second priority is the staff". The provider of the service's vision and values were of compassion, dignity, equality and promoting independence. The manager echoed this vision and values but added, "I want this to be a home from home, a place where people can feel safe and well cared for." Staff members were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the manager to engage with staff and reinforce the vision and values for the service. Additionally, the manager told us that they and the service provider would often observe care provision and staff interaction with people as well as complete unannounced spot checks out of hours to ensure that staff were adhering to the vision and values of the service.

Seaview Residential Home had up to date and appropriate policies in place to aid with the running of the service. For example, there was a whistle-blowing policy in place which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The manager showed us examples of where this had been followed and family members confirmed that they were always updated when their relative had an accident.

The provider notified CQC of all significant events and the home's previous inspection rating was displayed within the entrance of the home and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to prevent and control the risk of infection and to ensure risks to the health and safety of people were assessed and mitigated. Regulation 12 (2) (a) (b) (h)