

Seaway Nursing Home Limited

Seaway Nursing Home

Inspection report

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East Sussex
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Date of inspection visit:
10 February 2016

Date of publication:
15 April 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 10 February 2016. Seaway Nursing Home was last inspected on 16 June 2014, where no concerns were identified. Seaway Nursing Home is registered to accommodate up to 20 people who require support with nursing and personal care. They specialise in supporting older people, some whom are living with dementia or chronic health conditions. Accommodation was arranged over three floors. On the day of our inspection, there were 17 people living at the service. Seaway Nursing Home is part of a group of three services owned by the same provider in the Brighton and Hove area.

There was a manager was in post, however they had not currently registered with the CQC. The service had been without a registered manager for approximately five months. 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 2008 and associated Regulations about how the service is run.

People's medicines were stored safely and in line with legal regulations and people received their medication on time. However, safe procedures for the administration of the medication were not routinely being followed, which placed people at potential risk of receiving their medicines incorrectly. We have identified this as an area of practice that needs improvement.

Where people lacked mental capacity to make specific decisions, the staff were guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. However, despite senior staff having appropriate training and knowledge, we found that care staff had not received formal training around the MCA. We have identified this as an area of practice that needs improvement.

Staff had received essential training, however, this training had not routinely been updated. There were also limited opportunities for additional training specific to the needs of the service, such as end of life care, the care of people with dementia and caring for people with chronic conditions, such as diabetes. We have identified this as an area of practice that needs improvement.

People chose how to spend their day and they took part in activities in the service. It is acknowledged that meaningful activities had previously been planned and taken place for people. However, we saw no activities taking place on the day of our inspection, and no formal provision had been made to provide activities for people in the planned absence of the activities co-ordinator. We have identified this as an area of practice that needs improvement.

People were not actively involved in developing the service. Other than the complaints process, there were no formal systems of feedback available for people, their friends or relatives to comment on the service and suggest areas that could be improved. We have identified this as an area of practice that needs improvement.

The provider undertook some quality assurance audits to ensure a level of quality was maintained. However, further quality review and auditing systems needed to be kept up to date. For example, the most recent infection control audit had taken place in August 2015. Up to date policies and procedures were not readily available to provide clear guidelines for staff to follow. We have identified this as an area of practice that needs improvement.

Support for the manager to increase their knowledge, and to share learning and best practice to drive up quality at the service had not been made available or explored. Additionally, the manager was responsible for managing the service, but also split their time between being on the rota as the nurse in charge on some days. In light of the concerns identified in respect to medication procedures, staff training, oversight of documentation and auditing systems, it was clear that the current management arrangement in place was not effective and had resulted in a reduction in quality of the service. We have identified this as an area of practice that needs improvement.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. A relative told us, "I know [my relative] is safe". When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable in safeguarding adults and what action they should take if they suspected abuse was taking place.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. People were advised on healthy eating and special dietary requirements were met. People's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People told us they felt well looked after and supported and stated that staff were friendly and helpful. We observed friendly and genuine relationships had developed between people and staff. One person told us, "I am always treated with dignity and respect". A relative told us, "There is a good caring environment". People were encouraged to stay in touch with their families and receive visitors. Care plans described people's needs and preferences and they were encouraged to be as independent as possible.

People knew how to make a complaint. They said they felt listened to and any concerns or issues they raised were addressed. Risks associated with the safety of the environment and equipment were identified and managed appropriately.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, and the manager was always available to discuss suggestions and address problems or concerns. One member of staff told us, "We can go to the manager at any time, the manager is lovely". Another said, "We are a good team, we pull together when it's tricky, it's all about the residents".

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 consistently safe.

Medicines were stored appropriately, however, safe procedures for the administration of the medication were not routinely being followed.

Staff knew how to protect people from abuse and were aware what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the care sector.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Care staff had limited understanding around obtaining consent from people, but had not had any formal training around the Mental Capacity Act 2005 (MCA), and what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life.

Staff received training which was appropriate to their role, however this training had not routinely been updated. There were also limited opportunities for additional training specific to the needs of the service.

Staff had formal systems of personal development, such as supervision meetings. People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good ●

The service was caring.

People felt well cared for, their privacy was respected, and they were treated with dignity and respect by kind and friendly staff.

People were encouraged to increase their independence and to make decisions about their care.

Staff knew the care and support needs of people well and took an interest in people and their families supported them to provide individual personal care.

Is the service responsive?

The service was not consistently responsive.

People were supported to take part in a range of recreational activities, however no formal provision had been made to provide activities for people in the planned absence of the activities co-ordinator.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

People told us that they knew how to make a complaint if they were unhappy with the service.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Formal systems for people to provide feedback were not available. Up to date policies and procedures were not in place to provide clear guidelines for staff to follow.

Quality assurance was measured and monitored to help improve standards of service delivery. However, further quality review and auditing systems needed to be kept up to date. Opportunities for support and learning for the manager had not fully met their needs. Current management arrangements were not effective.

Systems were in place to ensure accidents and incidents were reported and acted upon. People commented that they felt the service was managed well and that the management was approachable and listened to their views. Staff felt supported by management and understood what was expected of them.

Requires Improvement ●

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 checked 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 took place on 10 February 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

One inspector and an expert by experience in older people's care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before our inspection we reviewed the information we held about the service. We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

We observed care in the communal areas and over the three floors of the service. We spoke with people and staff, and observed how people were supported to eat and drink. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as accident/incident recording and safety documentation.

During our inspection, we spoke with five people living at the service, three visitors, three care staff, the manager, the cook and the provider.

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. A relative told us, "I know [my relative] is safe". Everybody we spoke with said that they had no concerns around safety. However, we found areas of practice that need improvement.

We looked at the management of medicines. Nurses were trained in the administration of medicines. Prior to the morning medicines being administered, we observed the manager preparing medicines to be administered. We saw that they had removed seven people's medicines from their packaging and placed them into individual unmarked medicine pots on a tray. This practice is known as secondary dispensing or 'potting up' and does not follow good practice in respect to the administration of medicines, as outlined by the Royal Pharmaceutical Society of Great Britain (The Handling of Medicines in Social Care). Care home staff must not prepare medicines in advance for administration, as this practice can lead to accidental mix-ups and drug errors.

Additionally, it was evident that the recording of the medication administered for these people in their individual medication assessment records (MAR) would have been completed simultaneously at the end of the medication round, rather than individually after each specific administration. Care home staff should complete the MAR only when a person has taken their prescribed medicine, and the individual record should be completed before moving on to the next person. This is to reduce the risk of MAR's being recorded incorrectly. We raised this with the manager, who was aware that they were not following the correct procedure for the administration of the medication. They stated that this was not normal procedure and that this had been carried out due to time pressures on the day of our inspection. The manager subsequently administered and recorded the medication correctly for each person individually. We observed medicines being administered sensitively and appropriately by the manager. They administered them to people in a discreet and respectful way and stayed with them until they had taken them safely. We checked the MAR charts of the seven people and saw they were accurate.

Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. We also saw that regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge.

Nobody we spoke with expressed any concerns around their medicines. However, the above issues around secondary dispensing and recording are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014) We have identified this as an area of practice needs improvement.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training. Staff described different types of abuse and what action they would take if they suspected abuse had taken place.

There were systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We also saw safe care practices taking place, such as staff supporting people to mobilise around the service.

We spoke with the manager about the need to balance minimising risk for people and ensuring they were enabled to try new experiences. The manager said, "People take risks. We have one resident who is assessed to use a Zimmer frame. Sometimes he chooses not to. We advise him what is best, but he chooses to take the risk. We have another resident who likes to go out. He is not always safe, but he has capacity and we support him to go outside". Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The manager told us, "We have enough staff, they never come to me to tell me that they need more, but we do need more permanent staff. We are recruiting at the moment for one nurse and two carers". We were told agency staff were used and existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave. On the day of our inspection, the manager introduced an extra nurse into the service from another service in the group in order to free up time to assist with the inspection process. Feedback from people and staff indicated that on the whole they felt the service had enough staff and our own observations supported this. One person told us, "Staff answer my call bell quickly, but they are very busy". A member of staff said, "There's plenty of time to do things, so I think there is enough staff". Another member of staff added, "We've got enough staff".

Records demonstrated staff were recruited in line with safe practice. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had registration with the nursing midwifery council (NMC) which were up to date.

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. A relative told us, "I think the nursing care is excellent, I'm not worried about that". Another relative said, "They always keep me informed about my [relative's] health, as they know it worries me". However, despite the positive feedback we received, we identified areas of practice that needs improvement.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had a strong understanding of the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty.

We checked whether the service was working within the principles of the MCA. We saw that assessments of capacity were in people's care plans. However, care staff we spoke only had a basic understanding of the MCA and DoLS and they appeared vague and required prompting about the subject of obtaining consent from people. We also found that care staff had not received formal training around the MCA. This is a risk as staff may not have clarification about the actions they can take if someone does lack capacity, and the legal safeguards that govern this. We raised this with the manager and saw that only nursing staff and two out of nine care workers had received formal training around the MCA.

Staff had received training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, moving and handling. However, in line with the providers own timescales, much of this training required updates and we saw that these had not routinely gone ahead. We raised this with the manager who told us they were aware that several updates of training were behind and they had raised this with their regional manager. Updates of relevant training are important to ensure that care staff remain up to date with sector specific information, such as any new legislation and good practice guidelines within the sector.

Some staff had received specific training around the needs of people using the service. For example, nursing staff had received training for percutaneous endoscopic gastrostomy (PEG) feeding. This is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate. However, care staff had not routinely received specific training around the needs of people, such as training for end of life care, the care of people with dementia and caring for people with chronic conditions, such as diabetes. Staff we spoke with confirmed that this was the case. We raised this with the manager and saw that three nursing staff and two out of nine care

workers had received training around the care of people with dementia. Additionally, no care workers and only two nursing staff had received training around end of life care. The service provides support to older people, some whom are living with dementia or chronic health conditions. This type of training is significant to the roles of staff and the service, and would enable and empower staff to provide support in more specialist areas of social care, providing better outcomes for people.

The above issues in respect to staff training have been identified as areas of practice that need improvement.

Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. Staff told us that they received support to assist them to develop in their roles. We asked staff if they received regular supervision meetings and an annual appraisal. Supervision is a system of meeting formally to ensure that staff have the necessary support and opportunity to discuss any issues or concerns they may have. One member of staff told us, "We get supervision". Another said, "I've had supervision recently".

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available.

On the day of our inspection, everybody ate lunch in their rooms, which was their choice. We observed staff support people with their meals. Staff remained patient and supportive and continually offered choice and explanation around the food. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. Everybody we spoke with agreed that the food was good and they enjoyed a healthy diet. We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request.

People's weight was regularly monitored, with their permission. Some people were provided with a specialist diet to support them to manage health conditions, such as diabetes. We saw that details of people's special dietary requirements, allergies and food preferences were recorded to ensure that the cook was fully aware of people's needs and choices when preparing meals.

Care records demonstrated that when there had been a need was identified, referrals had been made to appropriate health professionals. A relative told us that they were very confident in the nursing practices at the service and that GP's were called when required. Staff confirmed they would recognise if somebody's health had deteriorated and would raise any concerns with the appropriate professionals. They were knowledgeable about people's health care needs and were able to describe signs which could indicate a change in their well-being. One member of staff told us, "We recognise if they are poorly, we would raise it with the nurses". The manager added, "[Person] was not very well and the carers raised it with me". We saw that if people needed to visit a health professional, such as a GP or an optician, or go to hospital, then a member of staff would support them.

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had been developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and that their independence was promoted. One person told us, "I am always treated with dignity and respect". A relative told us, "There is a good caring environment".

Interactions between people and staff were positive and respectful. There was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions with good eye contact and appropriate communication. Staff appeared to enjoy delivering care to people. A member of staff told us, "I think everybody should be treated like they were their own Mum and Dad, well fed and with dignity".

Staff demonstrated a strong commitment to providing compassionate care. We saw that one person was had become upset and we saw a member of staff sit with this person on two occasions and calm them down. It was clear that the member of staff knew this person well and could recognise ways to make them feel better. From talking with staff, it was clear that they knew people well and had a good understanding of how best to support them. They were able to talk about the people they cared for, what they liked and the things that were important to them. One member of staff told us, "We know the residents well. For example, one person likes to have a cup of tea first thing and put on a particular jumper in the morning. Another person always wants to have a very tidy room". Another member of staff added, "One lady likes to talk about her family and when they are going to visit. We sit with her and talk about it, and it reassures her. We have a good understanding of the people here".

Staff were respectful when talking with people, calling them by their preferred names. We saw staff upholding people's dignity, and observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "I am always treated with dignity and respect, especially when I am washed. I don't mind if the carer is male or female, everyone is so kind and compassionate". A relative said, "[My relative] was treated with great dignity and respect".

The staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection we observed people being given a variety of choices of what they would like to do, and empowered to make their own decisions. People told us they were able to make decisions about their care, and they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "I am able to choose the time I go to bed and when I get up. Sometimes I have a shower and I choose what I wear. They take me seriously". Another person added, "We can make our own decisions within our limitations". A member of staff told us, "We always give them choice around clothes and what they like".

Staff supported people and encouraged them, where they were able, to be as independent as possible. A member of staff told us, "We have one resident who I encourage to walk. I'll say, 'You come with me today,

let's go for a walk' and they will if they want to". Another member of staff said, "We always encourage people to wash themselves". The manager added, "We have one resident who through encouragement has gone from needing two carers to help him to one. We encouraged him to hold cups and do tasks himself". Visitors were also welcomed. The manager told us that there were no restrictions on when people could visit. A relative told us that they visited on four days a week and was always made to feel welcome. They added that other friends and relatives visited on the other days and were always well received.

Is the service responsive?

Our findings

People told us they were listened to and the staff responded to their needs and concerns. One person told us, "They listen to me". A relative said, "I am always consulted and kept up to date with the necessary special care my [relative] receives". However, despite the positive feedback we received, we identified areas of practice that needs improvement.

On the day of our inspection, there were not appropriate arrangements in place to meet people's social and recreational needs. The provider employed an activities co-ordinator who worked five days per week, however they were on annual leave for approximately two weeks and no formal provision had been made to provide activities for people in their absence. People spent most of their time sitting in their rooms listening to music or watching television. During the course of the inspection we found there was no opportunity for people to enjoy social activity or stimulation, or be supported to go out. The manager told us that there was an expectation that staff set aside time to visit people who stayed in their rooms on a one to one basis. However, this was not observed taking place during our inspection. Apart from the delivery of individual care, we saw little other contact from staff with people who remained in their bedrooms. We raised this with staff and the manager. One member of staff told us, "There's not enough going on for them, but the activity co-ordinator is away. There should be a lot more". Another member of staff said, "I think there are enough activities, but it would be good when the activities co-ordinator is away to have an extra 'floating' care worker to carry out activities".

We asked people and their relatives what they thought of the activities at the service. One person told us, "They have a sing song now and again and a pet company bring in goats, dogs and rabbits, but not very often". Another person said, "The carer takes me to Tesco's now and again". A further person added, "I would like to go to church, but I haven't been since I came here". A relative told us, "Activities are limited, but my [relative] only watches TV and DVD's". Another relative said, "They do not have time to sit and chat, and that makes it harder to build up relationships with nurses and carers".

We saw through activities recording that the activity co-ordinator had ensured that people who remained in their rooms and who may be at risk of social isolation had been included in activities and received social interaction. Their records showed that people had enjoyed activities they were interested in, such as playing cards, having their nails painted and reminiscing sessions. However, this information had only been recorded up to 21 January 2016 and we were unable to see what activities had taken place for people subsequently. It is acknowledged that meaningful activities had previously been planned and taken place for people. However, we saw no activities taking place, and no formal provision had been made to provide activities for people in the planned absence of the activities co-ordinator. We have identified this as an area of practice that needs improvement.

We saw that people's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. People confirmed they were involved in the formation of the initial care plans and were subsequently asked if they would like to be involved in any care plan reviews. Care plans contained personal information, which recorded details about people and their lives. A relative told us, "I

regularly sign the care plan". Comprehensive life histories had been completed with assistance of relatives and gave a picture of each person's life and preferences. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and help provide meaningful care.

Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required meeting those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. The manager told us that staff ensured that they read peoples care plans in order to know more about them. We spoke with staff who confirmed this was the case and gave us examples of people's individual personalities and character traits that were reflected in peoples care plans. One member of staff said, "We learn about people's backgrounds. One resident used to be a palmist and we always talk about start signs and she gives us palm readings. We know all about her life history". Another added, "The care plans are useful, they have good information in them about people".

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed by the manager or the provider. We saw that the procedure for raising and investigating complaints was available for people, and that systems were in place to investigate, respond and analyse complaints in order to improve the service delivered.

Is the service well-led?

Our findings

There was a manager was in post, however they had not currently registered with the CQC. The service had been without a registered manager for approximately five months. People and staff spoke highly of the service and staff commented they felt supported and could approach the management team with any concerns or questions. A relative told us, "I can ring the manager any time of day or night if I am worried. She also rings me". A member of staff said, "I would put my Dad in here". However, despite the positive feedback we received, we identified areas of practice that need improvement.

People were not actively involved in developing and improving the service. Other than the complaints process, there were no formal systems of feedback available for people, their friends or relatives to comment on the service and suggest areas that could be improved. Despite the service's policy stating that satisfaction surveys were to be given to people every six months, this had not happened. Additionally residents and relatives meetings did not take place. Having formal systems of feedback would enable providers to receive a snapshot of what is important to people, what is going well and what could be improved upon. Analysis of feedback enables providers to demonstrate the quality of their service, create actions to respond to feedback and drive improvement.

Policies and procedures available for staff to use were not up to date. For example, the policies around quality monitoring, person centred care and record keeping were based on previous health and social care regulations. The quality monitoring policy had been reviewed in August 2015 and was deemed relevant, however the regulations it reference ceased to exist in April 2014. We asked the manager if there were any further updated policies and procedures for the service, however, the manager did not know of any additional policies. Policies and procedures or agreed ways of working set out how the provider requires staff to work. They should incorporate various pieces of up to date legislation as well as best practice. It is important for staff to have access to and know where the most up to date written copies of policies, procedures, guidelines and agreed ways of working are kept that relate to their role. This is to enable staff to provide a good quality service working within the legal framework, and most importantly to aim to keep the individuals they support, safe from danger or harm.

The provider undertook some quality assurance audits to help ensure a good level of quality was maintained. We saw audit activity which included health and safety, medicine management and care planning. The results of which were analysed in order to determine trends and introduce preventative measures. However, further quality review and auditing systems were not kept up to date. For example, the most recent infection control audit had taken place in August 2015. We raised this with the manager, who told us that they would like to carry out audits on a monthly basis, but this had not been possible, due to time pressures with their role. The information gathered from regular audits, monitoring and feedback is used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered and minimise risks for people.

Registered managers and managers in charge of care homes play a key role in ensuring people are cared for safely and with acceptable standards of care. They are often the lead professionals in care home settings.

We spoke with the manager around support and opportunities to share best practice. They told us that they had not attended local quality and management forums held by the Local Authority and Clinical Commissioning Group (CCG), nor had they attended meetings with other managers in the same corporate group of homes as Seaway Nursing Home. They stated that this was because they were either unaware such meeting took place, or had not been invited. Support from providers around quality assurance and service delivery is vitally important. In addition, being able to access and share best practice through networking can create learning and improvement for managers, and also in outcomes for people using the service.

The manager was responsible for managing the service, but also split their time between being on the rota as the nurse in charge on some days. Feedback received from some people and relatives was that the manager was not 'visible' in the service. Two visiting relatives told us that they were unaware of who the manager was and a person told us that they didn't think the service had a manager, just nurses and care staff. A relative added, "The new manager does really well, but it is a lot for her, she is a nurse and the manager as well". We raised this with the manager and provider. The provider told us that it was common of a service the size of Seaway Nursing Home to have an arrangement whereby the manager was routinely allocated on the rota to carry out shifts as a nurse. However in light of the concerns identified in respect to medication procedures, staff training, oversight of documentation and auditing systems, it was clear that the current management arrangement in place was not effective and had resulted in a reduction in quality of the service.

We have identified the issues above, as areas of practice that need improvement.

We discussed the culture and ethos of the service with the manager and staff. The manager told us, "I really like this nursing home. The home is friendly, the staff are good and they have a good relationship with the residents. The residents are happy and we have good relationships with their relatives". A member of staff said, "It's lovely here, it's a nice place, with a nice atmosphere". Another added, "We take care of the residents and watch over them". In respect to staff, the manager added, "I have a gentle way with staff, I am supportive". Staff said they felt well supported within their roles and described an 'open door' management approach. One member of staff said, "The manager is approachable and would do anything for us". Another added, "I like it here, I love care work and I love this job".

Staff were encouraged to ask questions, discuss suggestions and address problems or concerns with management. The manager told us, "Staff can come to me and discuss things". They added, "I observe staff to see what they are doing, to look at their practice and support them". A member of staff said, "We can go to the manager at any time, the manager is lovely". Another said, "I can approach the manager, I have done with an issue before". A further member of staff added, "We are a good team, we pull together when it's tricky, it's all about the residents".

The service had a strong emphasis on team work and good communication and sharing of information. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff said, "In handover meetings, we share information about the residents and the shifts". Another said, "Handover between shifts are very useful". The manager added, "Handover meeting with nurses and staff are used to share information".

Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed. Staff knew about whistle-blowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistle-blowers were protected and viewed in a positive

rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

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 did not take formal enforcement action at this stage. 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
Diagnostic and screening procedures	The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g)
Treatment of disease, disorder or injury	