Qumran Care Limited

Eshcol House Nursing Home

Inspection report

12 Clifton Terrace
Portscatho
Truro
Cornwall
TR2 5HR

Tel: 01872580291

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 4 July 2017. The last focused inspection took place on 17 March 2017. The service was meeting the requirements of the legislation at that time. The focused inspection was carried out to follow up on a breach of regulations found at the last comprehensive inspection 17 December 2015.

Eshcol House is a care home which offers nursing care and support for up to 31 predominantly older people. At the time of the inspection there were 29 people living at the service. Some of these people were living with dementia. The service occupies a detached house over three floors. There was a passenger lift to support people to access the upper floors, however, this lift was out of order on the day of inspection visit.

Systems for the management and administration of medicines were not entirely robust. The service had reported a medicine error to CQC in April 2017. The wrong medicine was given to a person. The investigation in to this incident was robust and led to recommendations that specific actions be taken to help reduce the risk of future events. The recommendations seen at the inspection were not in place. Following the inspection the provider sent CQC information that stated it was "Written in retrospect." A meeting was held with the nurses to discuss the implementation of the recommendations. It had been decided not to implement the wearing of a red tabard during medicine rounds as it "Did not mitigate disruptions." The nurse was seen being disturbed during medicine rounds at this inspection. This meant the risk of a further error had not been reduced.

It was not always possible to establish if people had received their medicine as prescribed. There were some gaps in the medicine administration records (MAR). Handwritten entries on to this MAR had not always been signed by two staff to help reduce the risk of errors. Prescribed creams and liquids were not always dated when opened. There was one expired cream stored in the medicine fridge. Regular medicines audits were not being carried out. This meant any errors were not being identified in a timely manner.

Staff were not provided with formal supervision in line with the policy held by the service. Most staff had been provided with annual appraisals. However, many appraisals had been provided by an external consultant bought in by the provider. This did not provide staff with a reflective two way process with their line manager who knew of their practice. Whilst staffing rotas showed there were sufficient numbers of staff on shift and the registered manager monitored dependency scores in order to meet people's needs, staff reported being 'under pressure' and 'quite stressed'. Throughout the day of this inspection call bells rang constantly. Some people reported having to wait for staff to respond to them at times.

We walked around the service which was comfortable and warm. There was no pictorial signage for people who required additional support to orientate them around the building. Some of the communal areas were in need of redecoration and the carpets were worn and marked in places. Two of the bathrooms were not being used by people and where full of equipment. We were told there was a plan to change the use of these rooms in to a storage room and a wet room. The provider had commissioned a project manager. They were

in the process of addressing required actions identified at a fire assessment of the premises. There was a dining area. However, we were told this was not used by people living at the service. The dining table and chairs were used by staff during this inspection. People ate their meals in their bedrooms or at their chairs in the lounge.

The service had applied for appropriate Deprivation of Liberty Safeguards authorisations. We were told one authorisation was in place at the time of this inspection but the documentation relating to this was not available for review. The service did not have a copy of the authorisation. We contacted the Cornwall DoLS team who told us there was no authorisation in place. The registered manager was asked to contact the funding authority for the person to obtain the authorisation which was not present in the records for reference.

Care plans provided information related to people's care needs. Shift handover records also contained specific information about people living at the service such as if they were diabetic and their resuscitation status. Some information was not always accurate. For example, when people's needs had changed this was not reflected in their care plan. One person was diabetic and this was not indicated on the handover sheet. Some monitoring charts were not completed by staff as directed in people's care plans. There were gaps in these charts. Some people had lost weight recently. This had been recorded but no subsequent action was taken to review the person's risks or their care needs. Some people had been assessed as needing pressure relieving equipment on their beds and this had been provided. However, the correct settings for each mattress related to their weight was not recorded or monitored to help ensure people were protected from the risks associated with pressure damage to their skin.

The service had invited people and their families to attend meetings held at the service in order to seek their views and experiences of the service provided. Two meetings had been held, at one no people or families attended and at the second only two residents and one relative attended. Eshcol had received mostly positive responses to a survey carried out in November 2016.

Care plans were well organised and were reviewed regularly. However, people's changing needs were not always recorded such as when they lost weight. Where appropriate, relatives were included in care plan reviews. Some consent to care forms were not signed appropriately by the person, where they had capacity, or indicated when they were not able to do this. Where people did not have capacity to do this, only people with a lasting power of attorney for care and welfare are legally able to do this on behalf of the person. The service held records of any lasting powers of attorney held by people living at Eshcol.

Recruitment processes were safe. New staff were supported by a period of induction. Staff were provided with appropriate training to carry out their roles. Training was monitored and updates were provided as needed.

There were some activities provided for people. Some people were taken out in to the local area. A Head of Well being had been recently appointed to increase the amount of meaningful activity provided for people, particularly people cared for in bed.

People were treated with kindness, compassion and respect. People were supported by staff who knew how to recognise abuse and how to respond to concerns. Staff meetings were held and provided staff with an opportunity to air any concerns or suggestions they had regarding the running of the service.

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

able to get up and go to bed as they chose.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. All meals were cooked from scratch on the premises.

The registered manager was supported by two administrators and the provider. Staff told us they felt supported by the manager and were happy working at the service.

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 entirely safe. The systems for the management and administration of medicines was not entirely robust.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. However, the staff and people reported some shortages of staff at times and the staff felt under pressure.

Care plans recorded risks that had been identified in relation to people's care. However, these were not always reviewed when people's care needs changed.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

Is the service effective?

Requires Improvement

The service was not entirely effective. Most staff had received an appraisal. However, this was provided for some staff by an external consultant and stafff told us it was not a two way process. The service was not following its own supervision policy.

People had access to a varied and nutritious diet. However, some people had been recorded as having lost weight and this had not led to a review of their needs. No action had been recorded in the care files to show the service had identified this weight loss.

Staff were well trained. The registered manager monitored the training needs of the staff and provided updates as needed.

The management had an understanding of the Mental Capacity Act 2005. However, we were told a DoLS application was in place but there was no authorisation held in the person's file. Some consent forms were not always signed appropriately.

Is the service caring?

Good

The service was caring. People who used the service, relatives and healthcare professionals were positive about the service and

the way staff treated the people they supported.

Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. People did not always receive care and support that was responsive to their changing needs. Information provided for staff in care plans and handover sheets was not always accurate.

Monitoring records were not always completed by staff as directed in care plans.

People were able to make choices and have control over the care and support they received.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. The registered manager told us they were unable to return the Provider Information Return or the contact list for professionals working with the service, to CQC as requested due to a computer issue.

Policies held by the service were not always followed. Actions from incident analysis was not always effective in reducing the risk of further errors.

The registered manager was not always aware of the current needs of some people living at the service, such as their DoLS status and nutritional needs.

The registered manager was not auditing the service provided to people. For example, medicines administration.

There were clear lines of responsibility and accountability at the service.

Staff were supported by the management team.

Eshcol House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 4 July 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

The provider was sent 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 improvements they plan to make. This was not completed by the provider. We reviewed other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with two people living at the service. Not everyone we met who was living at Eshcol House was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with eight staff, two administrators and the registered manager. We spoke with one visitor.

We looked at care documentation for four people living at the service, medicines records, six staff files, training records and other records relating to the management of the service.

Following the inspection we spoke with two families of people who lived at the service and two visiting healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

Systems for the management and administration of medicines were not entirely robust. The service had reported a medicine error to CQC in April 2017. The wrong medicine was given to a person. The investigation in to this incident was robust and led to recommendations that specific actions be taken to help reduce the risk of future events. The member of staff involved in the error was found to rely on their familiarity with the people living at the service and did not always refer to the records when administering medicines. Nurses were being distracted during medicine rounds and this contributed to the error. The recommendation that the nurse wear a red tabard clearly showing they were administering medicines and not to be disturbed, were not in place at the time of this inspection. Following the inspection the provider sent CQC information that stated it was "Written in retrospect." A meeting was held with the nurses to discuss the implementation of the recommendations. At this meeting had been decided not to implement the wearing of a red tabard during medicine rounds as it "Did not mitigate disruptions." When this issue was raised with the registered manager at feedback we were not told of this meeting or the decisions taken as an outcome. The nurse was seen being distracted by care staff during medicine rounds at this inspection. This meant the risk of a further error was not reduced.

It was not always possible to establish if people had received their medicine as prescribed. There were some gaps in the medicine administration records (MAR). Handwritten entries on to the MAR had not always been signed by two staff to help reduce the risk of errors. Prescribed creams and liquids were not always dated when opened. This meant staff were not aware of the expiration of the item when it would no longer be safe to use. We found one prescribed cream which was stored in the medicine fridge had expired and not been disposed of. Regular medicines management audits were not being carried out. This meant any errors were not being identified in a timely manner.

The service were storing medicines that required cold storage, there was a medicine refrigerator at the service. There were records that showed medicine refrigerator temperatures were monitored to ensure it remained between 2 and 8 degrees centigrade. However, there were gaps in these recordings and it was not checked every day. This meant that any fault with the fridge would not be identified in a timely manner and the safe storage of medicines in the refrigerator could not be assured.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service held records of medicines ordered, received, administered and returned to the pharmacy.

The service was holding medicines that required stricter controls. We checked three items of the stock held against the records and they tallied. These medicines were all regularly checked and this was documented in the record book. There had been no discrepancies found at this checks. An audit trail was kept of medicines received into the service and those returned to the pharmacy for destruction.

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse

was taking place. They were aware of the whistleblowing and safeguarding policies and procedures. Not all staff had received recent training updates on Safeguarding Adults.

The service held the personal money for some people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and items they may wish to purchase. The money was managed by the administrator. We checked the money held for two people against the records kept at the service and both tallied.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were robustly audited by the registered manager. This meant that any patterns or trends were recognised, addressed and the risk of re-occurrence was reduced. We saw that such events had reduced over the recent months.

Care plans contained risk assessments for a range of circumstances including moving and handling, supporting people when they became anxious or distressed and likelihood of falls. Where some risks had been identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, one care plan directed staff to sit with the person while they ate their meals as they were at risk of choking.

Some people were at risk of becoming distressed or confused which could lead to behaviour which might challenge staff and cause anxiety to other residents. Care records contained information for staff on how to avoid this occurring and what to do when incidents occurred. For example, one care plan directed staff to ensure the person had something soft held in their hand during personal care as this calmed them.

We looked around the building and found the environment was clean and there were no unpleasant odours. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks.

The service was in the process of addressing required actions identified by the fire service during a recent inspection. Fire safety drills had been completed and all fire fighting equipment had been regularly serviced. Staff were in the process of receiving fire training updates. Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the premises.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references. Long standing staff had their DBS checks reviewed every three years to help ensure staff remained appropriate to work with vulnerable people.

Whilst staffing rotas showed there were sufficient numbers of staff on shift and the registered manager monitored dependency scores in order to meet people's needs, staff reported being 'under pressure' and 'quite stressed'. Throughout the day of this inspection call bells rang constantly. Some people reported having to wait for staff to respond to them at times. Comments included, "They (staff) are short sometimes and we wait a bit" and "Staff are stressed. Some go off sick, we have to be done a bit quick. I feel a bit rushed."

The staff team had an appropriate mix of skills and experience to meet people's needs. We saw from the staff rota there were usually between four and six care staff on duty in the morning and five in the afternoon, supported by a nurse on each shift. There were three staff who worked at night. Staff told us they had felt

under pressure recently when short notice absence led to only three staff being on duty in the afternoon over the past weekend. Despite this pressure staff told us they were a good team and worked well together. The provider had recently closed one of their care homes in the area and two staff from this care home were due to move to support the staffing levels at Eshcol House. Staff were optimistic that this would improve working pressures.

Requires Improvement

Is the service effective?

Our findings

We toured the building during our inspection. Some people living at Eshcol were living with dementia and were independently mobile. However, there was no pictorial signage to orientate them around the building. For example, easy to recognise pictures of the bathrooms and toilets. Some of the communal areas were in need of redecoration and the carpets were worn and marked in places. Two of the bathrooms were not being used. They were being used for the storage of equipment. We were told there was a plan to renovate areas of the service and to change the use of these rooms in to a storage room and a wet room.

Staff were not provided with regular one to one supervision by the registered manager according to the policy held at the service. Most staff had been provided with an appraisal. However, many appraisals had been provided by an external consultant bought in by the provider. We were told this did not provide staff with a reflective two way process by their line manager who knew their working practices. However, staff told us they felt well supported by the registered manager and were able to ask for additional support if they needed it.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We did not see any mental capacity assessments for people who had required applications to be made for restrictions to be authorised under the 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. The registered manager had applied for a Deprivation of Liberty Authorisation (DoLS) for several people at the service. We were told one authorisation had been granted but was unavailable for review as there was no information held at the service or in the person's care plan. We rang the Cornwall DoLS team to check on this authorisation and were told there was no authorisation in place for this person. The registered manager was asked to check with the person's funding authority to see if the authorisation had been assessed by them. The registered manager was advised that any documentation relating to this person's authorised restrictions should be held in the person's care plan.

We recommend that the service take account of the Mental Capacity Act 2005 Code of Practice, when assessing capacity and holding records of any DoLS assessments.

People living at the service were not always able to communicate their views and experiences to us due to

their healthcare needs. We observed care provision to help us understand the experiences of people who used the service. A Visitor told us, "Staff are brilliant, I can't fault them. Nothing is too much trouble."

Following the inspection we spoke with visiting healthcare professionals, comments included, "I am happy with the care provided at Eshcol, they kept in touch with me regularly which was helpful" and "They are good at communicating with outside professionals."

There was a dining area with table and chairs. However, we were told this was not used by people living at the service. The table and chairs were used by staff during this inspection. People ate in their bedrooms or at their chairs in the lounge. This meant mealtimes were not a social occasion. Food was prepared on the premises and looked appetising. There was a choice provided to people. Staff were available to support people with their meals as necessary. The kitchen had been inspected by the food standards agency and received a five star rating. People told us they liked the food. We spoke with the cook who was knowledgeable about people's individual needs and likes and dislikes. Where possible they tried to cater for individuals' specific preferences. They told us the menus had been recently reviewed and changes made in response to people's comments. We were told that only one person was having their food and drink intake monitored and recorded. This was due to the person being fed prescribed feeds via a tube.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. The induction was in line with the Care Certificate which replaced the Common Induction Standards. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone.

Staff demonstrated a good knowledge of people's needs and told us how they cared for each individual to ensure they received effective care and support. Staff told us the training they received was good. Training records showed most staff were provided with mandatory training such as moving and handling and safeguarding adults. However, some staff required this training and this was being planned. The registered manager monitored staff training needs.

People had access to healthcare professionals including GP's, opticians and chiropodists. Care records contained records of any multi-disciplinary notes. Visiting healthcare professionals told us that the dependency of people living at the service had increased over recent months and they were visiting more regularly to support the staff.

Good

Is the service caring?

Our findings

Families comments included, "(The person's name) is very well cared for" and "I think they care for (The person's name) very well."

We spent time in the communal areas of the service during our inspection. Throughout the inspection people were comfortable in their surroundings with little signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly. Staff were seen providing care and support in a calm, caring and relaxed manner. Interactions between staff and people at the service were caring with conversations being held in gentle and understanding way. Staff were clear about the backgrounds of the people who lived at the service and knew their individual preferences regarding how they wished their care to be provided.

People's dignity and privacy was respected. For example, staff always ensured doors and curtains were closed during person care. Staff spent time sitting and chatting with people. People appeared to be well cared for.

Bedrooms were furnished to reflect people's personal tastes. People were encouraged to have things around them which were reminiscent of their past to give their bedrooms a familiar feel.

Visitors told us they visited regularly at different times and were always greeted by staff who wereable to speak with them about their family member knowledgeably.

Families we spoke with who supported their family members due to capacity issues, were not aware of their care plan and what it contained. We asked the registered manager if the service had held any meetings for people or their families so that their views and experiences could be sought. We were told that people did not attend and no information was provided to the inspector. Following the inspection we were sent information by the provider stating that meetings were held and minutes were provided for two meetings. The minutes of a meeting 10 April 2017 showed no residents or relatives were present. The minutes of 28 July 2017 meeting showed two residents and one relative attended. The provider also sent further additional information to CQC which showed records of conversations held with family members relating to specific incidents, care provided and professionals visits for two people. These records did not show that these people's formal views and experiences were gathered.

Requires Improvement

Is the service responsive?

Our findings

Care plans were held in a lockable cupboard. However, this was unlocked and open during the inspection. The care plans provided information for staff on how to meet people's needs. Handover records also contained specific information such as if they were diabetic and their resuscitation requirements in the event of a cardiac arrest.

Some people required to be re-positioned every four hours and their skin to be checked for any pressure damage. These monitoring charts were held in people's rooms. They were not completed by staff as directed in people's care plans. There were many gaps in these charts. For example, gaps of up to ten hours were found in one person's charts where there were no records of the person having been re-positioned. Another person's charts ended at six o'clock in the morning of the previous day. However, there was no redness or skin damage reported. We judged that there was little impact on people at the time of this inspection and people were being provided with the care they needed but staff were not documenting this.

There was a handover sheet used by each shift change. This record did not contain all the relevant information for all the people living at the service. For example, one person was diabetic and this was not recorded on the handover sheet. The recent weight loss of two people identified at this inspection was not passed on via the handover sheet.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people had lost weight recently. This had been recorded by the care staff on a separate sheet to the care plan. We found that one person had lost 6 kgs and another 3 kgs in between May and June 2017. We checked these peoples care files. No subsequent action had been recorded in their care files to review these people's risks or their care needs. One person's care notes stated on five occasions since 15 June 2017 that they had declined food. There was a note stating the person was in "Visible decline". The nutritional risk assessment had not been reviewed and no guidance was provided to staff on how to ensure that these people had adequate food and drink. The registered manager was unaware of this issue. The service held a nutrition policy which stated, "The home will take appropriate steps to ensure any sudden weight loss/gain is reported and acted upon" and "The home will assess the nutritional needs of residents on a regular and on going basis taking into account and changes in their condition." This meant the service was not following its own policy.

Some people were being cared for in bed and had been assessed as being at risk of developing pressure damage of their skin. We found pressure relieving equipment had been provided. However, the correct settings for each mattress related to their weight was not recorded or monitored to help ensure people were protected from the risks associated with pressure damage to their skin. Staff were not aware of the correct settings for each mattress.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Families told us, "They (staff) seem to be on top of things" and "The nurses communicate well with us." People who wished to move into the service had their needs assessed to ensure the service was able to meet their needs and expectations.

People had access to some activities both within the service and outside. A Head of Well Being had recently been appointed to oversee an organised programme of events including regular trips out and visits from entertainers. We spoke with the member of staff who told us they should have protected time in the middle of their care shift, where they changed into different clothing to differentiate between their two roles, and provided activities. However, sometimes they were required to provide care and not activities. There was not yet a planned programme of activities at Eshcol. Some people who were cared for in bed were receiving one to one activities.

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were provided upon admission. People told us they had not had any reason to complain. The registered manager told us they did not have any complaints in process

Requires Improvement

Is the service well-led?

Our findings

The service was sent 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 improvements they plan to make. The provider requested an initial extension to the submission date for the PIR due to being away from the service. This was granted by the inspector. However, the provider was subsequently unable to complete the PIR due to a computer issue with the link provided. No further extension was requested. CQC also requested a contact list of professionals who work with the service to be provided prior to the inspection. This was not provided.

The service held a policy which stated staff should receive supervision six times a year with an additional appraisal. This was not being provided. This meant the service was not following its own policy. Staff told us they could not remember the last time they had supervision. Some people recalled the external consultant providing an appraisal which some did not find satisfactory as the person was not familiar with them and their practice over the past year.

There was a book marked as recording housekeeping issues to be addressed. This had several issues recorded in it that had not been signed off as attended to. One stated that a person living at the service had requested that a bird table be removed from outside their room as they had their cat living with them. Across this entry was marked 'NO' in large letters. The registered manager and the housekeeper was not aware of this book or the entries.

Following a recent medicine error a detailed root cause analysis was carried out in to the cause of the incident. However, regular effective medicines management audits were not being carried out. Concerns were found at this inspection with the management of medicines. The concerns found at this inspection had not been addressed.

At the end of 2016 the service notified us of serious pressure damage that had occurred with a person who was cared for in bed. The service told us that staff had been provided with additional training and of the need to closely monitor people cared for in bed. However, at this inspection we found people who had been assessed as being at risk of pressure damage, had many gaps in their recording charts where it could not be evidenced that re-positioning had taken place.

The nutritional policy held by the service was not being followed by staff. Monitoring records directed in care plans to be completed by staff were not being reviewed by the nurses or the registered manager.

The registered manager advised the inspector that there was a DoLS authorisation in place for a person living at the service, but no documentation was available for review. When we contacted the Cornwall DoLS team we were told there was no authorisation in place for this person. The registered manager was asked to contact the funding authority of this person, for this documentation which should be held in the person's care file.

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

The service is required to have a registered manager. 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. The service had a registered manager in post.

Relatives and staff told us the registered manager was approachable and friendly. Staff felt well supported by the management team.

There were clear lines of accountability and responsibility both within the service and at provider level. The registered manager was supported by two administrators and the provider. The registered manager was being supported to complete an Institute of Leadership and Management course. The registered manager worked in the service week days supporting staff. This meant they were aware of the culture of the service at all times.

Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes.

All record systems relevant to the running of the service were well organised and reviewed regularly. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.

There was a maintenance person in post with responsibility for the maintenance and auditing of the premises. Equipment such as moving and handling aids and wheelchairs were regularly serviced to ensure they were safe to use.

The provider was in the process of carrying out statutory work to meet the fire regulations. Updating of the service was required. We were told there was a plan to renovate and redecorate the common areas and adapt bathrooms. The passenger lift was out of order on the day of this inspection. A member of staff told us they had jarred their back when travelling in the lift when it broke down as it stopped before the floor level leaving a step. Staff were seen carrying meals and hot drinks up and down the stairs throughout the inspection. We were assured this had been reported and was being addressed. The boiler, electrics, gas appliances and water supply had been tested to ensure they were safe to use.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control make sure to make sure the risk is as low as is reasonably possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must assess, monitor and improve the quality and safety of the services provided. Information was not always up to date, accurate and properly analysed and reviewed by people with appropriate skills and competence to understand its significance. The provider must ensure that their audit and governance systems remain effective.