South Coast Nursing Homes Limited

# Pentlands Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 12 and 13 February 2018 and was unannounced.

Pentlands Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Pentlands Nursing Home is registered to provide accommodation and care for up to 32 older people. The service provided care to 27 people at the time of the inspection. Pentlands Nursing Home is a large detached building with accommodation on two floors and a passenger lift to all the floors. All bedrooms are single and each has an suite bathroom or en suite toilet. There are also communal bathrooms on each floor. Each bedroom has a ceiling track hoist to people can be moved without the need for a mobile hoist. Communal lounge and a dining room are also provided. people have access to outside space in the garden.

There was a registered manager in post. 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.

Pentlands Nursing Home is a care home with nursing services and is registered to provide accommodation and care for up to 32 older people. Pentlands Nursing Home is a large detached building with accommodation on two floors and a passenger lift to all the floors. The service provided care to 27 people at the time of the inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People's views were sought as part of the service's quality assurance process and changes were made following comments from people. There were a number of audits and checks on the safety and quality of the services provided. Whilst these were comprehensive we identified one area where this needed to be in more detail to ensure adequate checks on safety were maintained. We have made a recommendation about this.

People and their relatives said they felt the service was safe. Staff were trained in safeguarding procedures and had a good awareness of the importance of protecting people. Risks to people were assessed and action taken to mitigate these.

Medicines were safely managed. Sufficient numbers of staff were provided and checks were made on the suitability of new staff to work in a care setting. The service was clean and hygienic. Reviews of care and incidents took place often in conjunction with local primary medical teams so improvements could be

made.

People's health care needs were assessed and any medical needs followed up.

Staff were provided with a range of training including an induction for newly appointed staff and nationally recognised qualifications in care. Staff were encouraged and supported to enhance their skills and knowledge. The service had links with a local college which provided training.

People's nutritional needs were met. Nutritious and varied meals were provided and people were able to choose their meals. Specialist diets were provided such as for people living with diabetes or those whose needs meant they were not able to chew or swallow food easily.

The premises were well maintained and adapted for those with mobility needs such as ramped areas for wheelchair users and track hoists in all bedrooms so people could be lifted without the need for a mobile hoist.

Where people did not have capacity to consent to their care and treatment this was assessed. Where these people had their liberty restricted an application for a Deprivation of Liberty Safeguards (DoLS) had been made to the local authority.  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's right to privacy and independence were promoted. Staff treated people with kindness and as individuals. People and their families were consulted about their care although we noted this was not always clearly detailed in care plans.

People received responsive care. Each person's needs were assessed and recorded along with care plans which were individualised to show how care needs should be met. Records were maintained on an electronic system which allowed staff to easily access and monitor people's changing needs.

The complaints procedure was available and people reported that they were able to raise any concerns or issues which were resolved. Records of complaints and how they were dealt with were maintained. These showed a response was made to complainants along with an apology, if relevant, and as set out in the Duty of Candour regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further information is in the detailed findings below

## 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 has deteriorated to Requires Improvement. Whilst the premises were safe action had not been taken to ensure people were always safe whilst building works were carried out. We have made a recommendation about this.

### Is the service effective?

**Good**

The service has improved to Good.

As recommended by the previous inspection report improvements have been made regarding care plan details regarding people's capacity to consent. Also as recommended by the last inspection report the calculation of percentage weight loss or gain was found to be have been implemented.

### Is the service caring?

**Good**

The service remains Good.

### Is the service responsive?

**Good**

The service remains Good.

### Is the service well-led?

**Good**

The service remains Good.

# Pentlands 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.

This inspection took place on 12 and 13 February 2018 and was unannounced. The inspection was carried out by one inspector 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 service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. 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. We also looked at information sent to us by the provider following the inspection.

During the inspection we spoke with eight people and four visiting relatives or friends of people who lived at the home. We spoke with three care staff, the activities coordinator, two chefs, the registered manager and a member of the nursing staff team. We also spoke to the provider's director of nursing.

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) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of

medicines administered to people and complaints. We looked at staff training records, staff duty rosters and staff supervision records. We also spoke with a GP who was visiting the service.

Requires Improvement

# Is the service safe?

## Our findings

At the time of the inspection communal areas were being redecorated. We noted workmen were present when this was taking place to ensure people were safe. We asked the registered manager if the risks to people and visitors had been formally assessed. She replied that this would normally have been done but had not due to the inspection taking place. Following the inspection the provider informed us that a risk assessment had been carried out and sent a copy to us. The risk assessment included details about the building work and measures to keep people and visitors safe. However, during the inspection we noted in one corridor that workmen were not present and tools were left balanced on handrails and dust sheets were on the floor. We observed people had access to this area which meant there was a risk to them. Whilst the risk assessment had identified possible risks it was not in sufficient detail in highlighting what needed to be done to mitigate the risks such as monitoring the areas affected to ensure people and others were always safe. Sufficient action had not been taken to keep people safe from equipment. We therefore recommend the risk assessments regarding any building work takes account of all risks and action needed to ensure people are safe.

People told us they felt safe at the service. For example, when we asked people if they felt safe they responded as follows,"Yeah, I am being looked after very well, the entrance is secure, I am safe and relaxed with staff," and, "Yes because there is always somebody here."

Staff were aware of safeguarding procedures and what action they should take if they considered a person had been abused. For example, staff were aware of the different types of abuse such as emotional, physical or financial. Staff showed they were committed to promoting people's right to be protected and to live in a safe place. The service had safeguarding policies and procedures and staff received regular training in safeguarding procedures.

Each person had care records which included risk assessments and care plans to mitigate the risk of harm to people. The assessment included the likelihood and impact of any risk and a subsequent score of the degree of risk. The risk of pressure areas developing on people's skin was assessed along with a care plan of what staff should do to minimise this. The staff used electronic records which they could access through a hand held device. Staff said this gave them ready access to people's changing needs and allowed them to monitor people more easily than paper records. The system also had a built in prompt so that staff would know when to support someone. Staff entered records on the devices when they supported people and these showed people were assisted as set out in the care plans. We did, however, notice one person's care plan stated they needed to be repositioned every two hours, but the records showed this was taking place regularly but not two hourly and in some instances at more than four hours. This was discussed with the registered manager who confirmed this had not had an impact on the person as they remained free from any pressure damage to their skin. The registered manager also stated the person may have been repositioned between these times when they got up or were assisted with personal care. The registered manager agreed she would check this to ensure the person was appropriately supported and reminded staff to always complete a record to show people were repositioned.

Risks of falls and possible malnutrition or dehydration were assessed and care plans showed the action staff needed to take to keep people safe. Where needed, referrals had been made to specialist services such as the dietician or speech and language therapist (SALT) where people were at risk of malnutrition or had difficulties swallowing food. Arrangements were made for people's food to be softened or pureed if needed. The kitchen staff had a record of each person's needs regarding this and served food accordingly, with the room number of each person on a plate cover, so people received the right meal.

Where specialist equipment was used, such as bed rails or hoists to move people there were risk assessments to ensure people were safe. Each bedroom had an overhead track hoist for moving people and air mattresses were in place to help alleviate pressure areas developing on people's skin. Checks were made that air mattresses were set at the correct pressure.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical wiring, gas heating, electrical appliances, hoists and passenger lift. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked each week. Radiators had covers in order to prevent the risk of people being burnt and first floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. There were health and safety risk assessments regarding the environment.

Sufficient numbers of staff were provided to meet people's needs. Staff considered there were enough staff to look after people well. Relatives also said there were enough staff. Five of the eight people we spoke with said there were enough staff. Two people said there were times when there were not enough staff but were not specific about this. During the day time there were nine care staff on duty plus a registered general nurse (RGN). The service did not use agency RGNs or care staff unless needed and could utilise staff from its own pool of bank staff when needed. We observed there were enough staff on duty. Staff responded to people when they asked for assistance and were deployed sufficiently that people were safely supported at lunch. Night time staffing consisted of one RGN with five care staff.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that RGNs were registered with the Nursing and Midwifery Council (NMC).

We looked at the service's medicines' procedures. Staff were trained in the handling and administration of medicines and this included a competency assessment to ensure they administered medicines correctly. Medicines administration records (MARs) showed staff recorded their signature each time medicines were administered. The MARs showed people received their medicines as prescribed. There were regular audit checks to ensure people received their medicines safely and as prescribed.

The home was found to be clean and hygienic as well as free from any offensive odours. People and relatives commented that the home was always clean. Staff wore personal protective equipment to prevent the spread of infection. Hand sanitisers were in place for staff and visitors to use. The kitchen was clean and well maintained and had been awarded five stars for food hygiene by the environmental health department. Infection control audits were carried out.

Incidents and ongoing care was reviewed in conjunction with other agencies. The registered manager and staff took part in weekly meetings at a local GP practice where the care of people was reviewed and discussed. The clinical lead and deputy manager at the service said this involved the examination of any

incidents so that lessons could be learnt or action taken regarding procedures for hospital admission. Care records showed people's changing needs were reviewed and care plans updated when needed.

Good

# Is the service effective?

## Our findings

At the last inspection of 28 and 29 September 2015 we found the service was not always effective and made a recommendation about this. This was because care plans did not always include details about people's capacity to consent to care and treatment and that the monitoring of any weight loss or gain was not recorded as a percentage. At this inspection we found the provider had taken action to address each of these shortfalls.

People told us they received the care and treatment they needed. Relatives also spoke highly of the care provided by the staff; for example, one relative said, "Every member of staff from the matron to the cleaners made an effort to be pleasant, and nothing was too much trouble. The care received was truly outstanding." People and their relatives said care and treatment took account of people's wishes.

The staff worked well with other health care services and a nurse practitioner from the local GP practice visited the service each week when the needs of people and the appropriate care were discussed. A visiting GP described the service as, "Really good. Pretty much the best in the area. The personal care and nursing care is always good. The staff always attend meetings at the practice and are always engaged with us."

Records showed how people's needs were comprehensively assessed prior to being admitted to the service. The local GP practice provided a personalised care plan to the service for those people being admitted who were registered at the practice. The preadmission assessment reflected people's medical and social care needs. Care records also showed how people's health care needs were monitored and treated, such as catheter care, wound care and continence care. Arrangements were made with health care providers regarding eye sight checks, chiropody services and a reflexologist.

Care and nursing staff were supported with training and supervision. The service had links with a local college who provided a number of courses for staff. The service was also approved by the University of Brighton as a suitable placement for student nurses under the mentorship of the registered manager or deputy manager. The service was supported by the provider's clinical team of registered nurses who sourced current guidance from national agencies such as the Nursing and Midwifery Council (NMC) and the National Institute for Clinical Excellence (NICE). The registered manager said this had led to policies and procedures being updated such as for medicines.

We asked staff about their training which they described as good; one staff member commented, "There's loads. The in- house training is amazing." The provider also had its own training team. Courses considered mandatory for staff included moving and handling, infection control, resuscitation, safeguarding, dementia care and the Mental Capacity Act 2005 (MCA). The service employed 46 care staff all of whom (except one) had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2 and above. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff told us they had access to specialist courses so they could develop their skills in providing care to people with Parkinson's disease, diabetes and mental health needs. Nursing staff also had training in wound care and

palliative care. There were good links with a nurse practitioner at a local GP practice who provided training and guidance in clinical procedures when needed.

Newly appointed staff received an induction to prepare them for their role. Records of staff induction were maintained and showed staff had registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. A care staff member said their induction prepared them for their role and involved an observed assessment and 'signing off' of their competency to provide care.

Staff said they received regular supervision and appraisals. They said this allowed them to raise any issues about care or their training needs. Records showed staff received regular supervision.

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). 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 service had policies and procedures regarding the MCA and the associated Code of Practice. Staff were trained in the MCA and DoLS. People's capacity was assessed regarding specific decisions. Where appropriate, applications were made to the local authority for people's liberty to be restricted for their own safety. At the time of the inspection the local authority were processing DoLS applications for those people who did not have capacity and had their liberty restricted to keep them safe The registered manager had a good understanding of the MCA. Staff also had a good knowledge of the principles of the MCA and said they supported people's rights to make their own decisions and to be as independent as far as feasible.

People were supported to have sufficient food and drink. We asked seven people if they liked the food and all but one person said they did. We asked thee relatives about the food and they each responded by saying it was of a "good" or "excellent standard." There was a menu plan which showed varied and nutritious meals with choices at each meal. People were asked in advance what they would like to eat and the day's menu was displayed in the hallway. The chef told us meals were homemade and from fresh ingredients including fresh fruit and vegetables. We observed staff assisted people to eat when this was needed. Nutritional needs for people were assessed using a Malnutrition Universal Screening Tool (MUST). Where needed people had a care plan for eating and drinking, which included details of the support needed, plus any high calorie snacks and fortification of foods needed to increase calorific value as well as any preferences. Drinks were available to people in their rooms and staff brought drinks and snacks to people at regular intervals. People's weight was monitored. Referrals had been made to health care professionals where assessments indicated people were at risk of losing weight or had problems with swallowing food.

The premises were found to be well maintained and promoted the dignity of people. Following feedback from people changes were made so people could more easily access the garden. People were seen to be able to access all areas of the home and there was enough space so people could be moved in wheelchairs or recliner chairs. There was ramped access and a passenger lift so people with mobility needs could access communal areas and their bedrooms. A relative said activities were provided in the ground floor lounge -

dining room which was an area where people could meet. Each bedroom had an en-suite and were decorated well. A relative described the bedrooms as, "Beautiful renovated rooms and en-suites."

Good

# Is the service caring?

## Our findings

People said they were treated with kindness and respect by the staff. One person said they were not always treated well by one or two staff. This was raised with the registered manager who took action to look into this with the person and made a referral to the local authority safeguarding team. Relatives also commented that staff were kind and caring. For example, one relative said, "Very kind and caring staff, many of whom have been there for a long time, who are genuinely interested in giving the residents the best possible care."

The service had an equality and diversity procedure for staff recruitment and policies regarding diversity and equality for the care and treatment of people using the service. The Statement of Purpose included statements of the provider's commitment to the values of privacy, dignity, choice, fulfilment, rights and the independence of people. These values were reflected by the staff team. The provider's Statement of Purpose also highlighted how people's diversity was promoted, such as in supporting people to adhere to their religious and cultural beliefs.

Staff demonstrated values of compassion and of treating people as individuals. People's rights to privacy and to being treated with respect were the foundation of the care they provided. For example, one staff member said, "It has to feel like a home. We have to treat people with respect. It's like a family. Everyone knows everyone by name. People know the names of staff. It is important to treat people as you would like to be treated." Another staff member said they treated people with respect and dignity as well as listening to people adding, "We never rush them." This same staff member said if the values of treating people with respect and dignity were not reflected by other staff they would raise it. Staff all said they treated people as individuals and acknowledged people's differences and preferences.

We observed staff treated people with kindness and warmth. Staff interacted well with people and spoke to them whilst they assisted them. When staff supported people to eat they did this in a calm manner and explained what they were doing as well as engaging them in conversation even when people had limited communication. People responded to staff in turn with smiles and conversation.

Care plans were individualised and personalised to reflect how people liked to be supported and how they spent their time. These were recorded to a good standard with full details about people's biography, hobbies, interests and daily preferences. People said they were consulted about their care and that care was provided in the way they wished. People confirmed they were able to exercise choice, such as in meals, how they spent their time, and, what time they went to bed. Whilst care plans reflected people's individuality and choice of lifestyle they did not clearly show people were fully consulted and had agreed to their care. The registered manager was aware of this and was looking into the electronic record system being able to provide this facility.

Life histories were included in care plans and staff had a good understanding of people's background and preferences.

Relatives said they were able to visit at any reasonable time and were always made to feel welcome.

People said their privacy was acknowledged and we observed staff knocked on people's bedroom doors before entering. The Statement of Purpose set out how people could have a bedroom key for privacy and security if they wished. The premises had closed circuit television (CCTV) in communal areas as an additional safety measure. There was a policy and procedure for this which included details about consulting people and their relatives about the CCTV, the reason for its use and how its use did not compromise the privacy of people. There was also a notice for visitors and people to be made aware of the CCTV. The registered manager was made aware of the guidance provided by the Information Commissioner's Office on completing a privacy impact assessment.

Good

# Is the service responsive?

## Our findings

People received care which was responsive to their changing needs and a relative stated the palliative care was particularly good. For example, one said, "The staff are so attentive, if you want anything it's there." We observed people were looked after well.

People were aware that the service had records about their care needs and people said they were consulted about their care. People gave mixed responses about how far they were involved in contributing to their care plan; for example, one person said they were involved, two people did not know if they contributed or not and one person said they were not involved. People and their relatives, however, said they were asked about what care was needed and how they would like to be supported.

An assessment of people referred for possible admission to the home was carried out in conjunction with a local GP practice. Each person had comprehensive assessments of their needs and corresponding care plans. These covered a wide range of health and personal care needs. The care plans reflected people's preferences for how they would like to be supported and gave staff clear guidance on how to support people. Assessments, care plans and daily records were entered on a care records information technology system devised for nursing care. Staff had access to these on a small tablet device and could enter updates as care was provided. Staff felt the system worked well but took time to adjust to. For example, one staff member said, "We can easily look back at what has happened. We can create a timeline from which I can gauge if someone is getting better or worse or if there is a pattern." Staff said the system allowed them to monitor needs such as weight and food and fluid intake more easily. The system also prompted staff to carry out certain tasks and could be used for passing messages to staff. Care plans included details to show people's rights to lead an independent lifestyle were promoted such as daily lifestyles and choices. Care records and discussion with staff also confirmed people's needs regarding sexuality and personal relationships were assessed and considered in a way which promoted people's rights. The registered manager and staff understanding of people's needs regarding personal relationships and made arrangements for these to be met, where this was relevant.

Care records showed people's social and recreational needs were assessed. A range of activities were provided for people and the service responded to people's requests for specific activities via the residents' meeting such as outings, entertainment and better access to the garden in the summer. Activities were provided by specific staff on each day including weekends; these were set out on a weekly plan displayed in the hall. The activities staff said people were asked what they would like to do. People said they took part in activities and a relative commented that a theatre group performed a pantomime to the residents in the lounge which was enjoyed by people.

The complaints procedure was provided to people in the Statement of Purpose. People and their relatives said they knew what to do if they had a complaint. One person described how they raised an issue with a member of staff and said this was written by the member of staff and prompt changes made to resolve the issue to the satisfaction of the person. Where complaints were made there was a record of this including details of how it was looked into and a response to the complainant. One of these included an apology to a

complainant. The provider had a Duty of Candour policy which is required by Regulation 20 of the Health and Social Care Act 2008 and outlines what providers must do when things go wrong and an apology when applicable.

There were good links with a local hospice so staff could update their skills and knowledge in end of life care. A relative commented that the end of life care "was truly outstanding." Registered nurses completed recognised training in end of life care at a local hospice. The links with the hospice also allowed staff to seek advice and support when needed. At the time of the inspection there were no people in receipt of end of life care. There were end of life care plan pro formas for people, which were comprehensive and included health care needs as well as preferences such as spirituality. The registered manager and staff told us of the remembrance tree in the garden for those people who passed away at the home and how this had helped family members to deal with their loss.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. The registered manager said information could be provided to people in formats which could be used for those with communication needs or for those who spoke a different language. For example, by using pictures so people could see the meals on offer. Also, people's communication needs were assessed to identify when people needed support with this. The registered manager, however, was not fully aware of the AIS and the provider did not have any policies or procedures regarding this. The registered manager confirmed this was being looked into so the service had policies and procedures about the Accessible Information Standard (AIS).

Good

# Is the service well-led?

## Our findings

People, their relatives and staff made favourable comments about the openness and availability of the registered manager, which promoted a positive culture. For example, staff said they were able to express their views or concerns at either the staff meetings or by directly approaching the registered manager or deputy manager. A staff member said, "We can speak to the manager or deputy. There's always time to talk if needed. We are listened to." Staff also demonstrated their commitment to promoting people's rights to being treated well and that they would take action if they felt the service was not promoting its ethos of being homely and family oriented. Relatives said of the registered manager. "I think she is first class and her team as well," and, "Very good, very conscientious and very helpful."

The Statement of Purpose set out the service's aims and values of dignity, privacy, choice fulfilment, rights and independence which we found were reflected in the service provided to people. Staff promoted people's rights to a good standard of care. Mechanisms were in place to consult and involve people and their relatives in decision making at the service. This was done by the use of surveys and at residents' and relatives' meetings where people and relatives could raise issues and set agenda items. The survey results were summarised and displayed in the entrance hall. Any issues raised were looked into and changes implemented, such as improving activities and introducing pictorial menu choices for people living with dementia. Feedback from the NHS commissioning group referred to caring and professional staff.

There was a registered manager in post. 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 registered manager was aware of her responsibilities and for ensuring the skills and knowledge of the staff team and herself were updated. Action had been taken to look at and ensure the service met the additional key lines of enquiry (KLOEs) introduced by the Care Quality Commission in November 2017.

There was a system of management delegation whereby RGNs were operationally responsible in the absence of the registered manager and took a lead role in coordinating care. The provider supported the service with a training team and a director of nursing.

A range of audits and checks were carried out to assess and monitor and improve the quality and safety of the service. Risk assessments were checked and audited as well as audits of care plans, medicines and other care practices. There was a system for recording and analysing incidents such as when people fell which looked at predisposing factors, where they occurred and what changes could be made to reduce the likelihood of a reoccurrence. There was a monthly quality assurance audit by the directors of the provider which looked at care and the premises. Health and safety and infection control audits were carried out. At the time of the inspection communal areas were being redecorated. We noted workmen were

The staff worked well with external agencies such as local colleges and universities. The working relationship with the local GP group practice was effective in ensuring people received coordinated care,

that information was shared and people's needs were reviewed so improvements could be made.