Midland Healthcare Limited

Rushey Mead Manor Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 March 2017 and was unannounced.

Rushey Mead Manor provides nursing and residential care for up to 50 older people, some of whom are living with dementia and/or physical disabilities. The home caters for people from a range of cultural backgrounds. It was purpose built with accommodation on two floors and a passenger lift for access. The service has lounges, a dining room, and gardens. When we inspected there were 45 people living at the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection the service did not have a registered manager, however the manager had submitted an application to register with CQC and this was being processed.

People and relatives told us the culture at the service was open and friendly. There was sense of community spirit and we saw that people, relatives and staff got on well with each other. People told us they were happy at the service and there was lots of laughter and positive comments when we discussed the service with them.

People told us the manager and staff were friendly and approachable. They said the manager often sat with them, shared sweets, and asked how they were and what they thought of the service. They said that if they had any concerns they would tell the manager or a staff member and they felt they would be listened to and action taken in response.

During our inspection visit we observed that staff kept people safe. We saw them assisting people to move about the service safely, have meals and drinks, and take their medicines on time. All the staff knew how to protect people from harm and who to go to if they had concerns about any person's well-being.

People told us there were enough staff on duty to keep them safe and meet their needs. During our inspection staff were always available to assist people. Both nursing and care staff were employed at the service. Staff also worked closely with local healthcare professionals to ensure people's needs were met.

The staff were well-trained and had the knowledge and skills they needed to work at the service. For example, they had recently attended a course in dementia care to help them work effectively with people diagnosed with this condition. Staff told us the manager was supportive, had an 'open door' policy, and they could approach her at any time for advice.

People told us they liked the food provided. The kitchen staff prepared a wide range of cuisine to ensure

people's dietary needs were met. They catered for Asian vegetarian, halal and non-halal, English, diabetic, and soft diets. We saw there were jugs of fresh water in all communal areas to encourage people to drink fluids to protect themselves from dehydration.

We observed many caring interactions between staff and the people they supported, and people and relatives said the staff were caring and kind. Relatives told us they were always made welcome when they visited the service.

People using the service spoke a range of languages including Gujarati, Hindi, English, Punjabi and Urdu. All staff spoke English and most spoke some Asian languages. During our inspection visit we observed staff talking with and reading to people in their first languages.

People told us the staff provided them with personalised care. Staff were familiar with the information in people's care plans. They knew people well and this helped to ensure they provided them with responsive care and support. Care plans were regularly reviewed to take into account people's changing needs.

The service had an activity co-ordinator and we observed an organised activity taking place in the afternoon when a group of people listened to Hindu music and then staff read to them from a Hindu religious booklet. We could see that people had enjoyed this activity and taken an active part in it. Other faiths were also catered for at the service and a range of religious festivals celebrated.

The premises were undergoing refurbishment when we inspected. However the provider had not identified that some areas were in need of immediate attention and more thorough cleaning.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People using the service felt safe and staff knew what to do if they had concerns about their welfare.

Staff supported people to manage risks whilst supporting them to be independent.

There were enough staff on duty to keep people safe and meet their needs. Medicines were safely managed and administered

Is the service effective?

Good

The service was effective.

Staff were trained to support people safely and effectively and seek their consent before providing care.

Staff had the information they needed to enable people to have sufficient to eat, drink and maintain a balanced diet.

People were assisted to access health care services and maintain good health.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and treated people with dignity. They communicated well with the people they supported.

People were encouraged to make choices and be involved in decisions about their care. Staff met people's cultural needs.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

People had the opportunity to take part in group and one to one

activities.

People knew how to make a complaint if they needed to and support was available for them to do this.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider used audits to check on the quality of the service. However these had not identified the improvements to the premises that were needed.

At the time of our inspection visit the service did not have a registered manager.

The service had an open and friendly culture and the manager was approachable and helpful.

The manager and staff welcomed feedback on the service from people and relatives.

Rushey Mead Manor Care and 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 15 March 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor, and an expert by experience. A specialist adviser is a person with professional expertise in care and nursing. Our specialist advisor on this occasion had nursing expertise. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience on this occasion had expertise in the care of people diagnosed with dementia.

Prior to our inspection visit we looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. They raised a small number of issues about the service and we have taken these into account.

We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We spoke with eight people using the service individually, six people using the service as a group, and three relatives. We also spoke with a visiting social care professional, the manager, the lead nurse, another nurse, the care co-ordinator, two senior care workers, three care workers, the administrator, the cook, and the maintenance manager.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked at four people's care records.

Good

Is the service safe?

Our findings

All the people and relatives we spoke with said they thought the service was safe. One person told us, "I would rather be at home but it's alright here. They [the staff] and know what they are doing. The family can visit when they want to. It's safe living here." A relative commented, "I am happy my [family member] is here, it's safe and the medications are given." A visiting social care professional said they had never seen unsafe care during any of their visits to the service.

During our inspection visit we observed that staff kept people safe. We saw them assisting people to move about the service safely, using moving and handling equipment where necessary. Staff were available in communal areas if people needed support and regularly checked on people who were in their rooms, completing observation charts to show they had done this. One relative told us, "My [family member] has dementia and is unable to press the buzzer [the call bell in their room] if they need help. The staff see them hourly. This is enough because my family are visiting constantly."

The provider's safeguarding policy was up to date and told staff what to do if they had concerns about the well-being of any of the people using the service. All the staff we spoke with understood their safeguarding responsibilities. One staff member told us, "[If we have any concerns] we tell the manager or the nurse in charge straight away and we make sure they do something about it. If they don't we tell the owner and social services."

Written information on the 'residents and relatives notice board' reminded people of their right to be safe and told them what to do if they had any concerns. However this was in English so might not be understood by all those using or visiting the service. We discussed this with the manager. She told us safeguarding was explained verbally to people and relatives when they first came to the service and again at care reviews. However she said she would look at providing safeguarding information in different languages in future.

During our inspection visit one person had a fall. Care staff and a nurse immediately went to assist the person. The nurse carried out first aid and called an ambulance due to the possibly that the person had suffered a fracture. The person was kept still and made comfortable. Staff placed a blanket over them and a pillow under their head, and the nurse stayed with them until paramedics arrived. This was an example of staff taking appropriate action in response to an accident in line with the provider's policy on this.

The service had a designated smoking room for people who wished to smoke. The room was equipped with a fire sprinkler system in the ceiling in case of fire. We observed that a person using this room had cigarette burns on their clothing. We discussed the risks of injury to smokers with the manager. She told us that staff checked on the person every hour and completed an observation chart. She agreed to put an individual risk assessment in place for any person who smoked to help ensure that, as far as possible, their safety was maintained.

We looked at how staff at the service managed risks so that people were protected from harm. All the people using the service had risk assessments in place for where they might be at increased risk to their welfare or

health, for example, with regard to moving and handling, tissue viability, and nutrition and hydration.

We looked at risk assessments belonging to four people using the service. These had been written in consultation with the people themselves, their families, and, where appropriate, health and social care professionals. They focused on minimising risk while enabling people to remain independent and make choices about their lifestyle.

One person had a risk assessment in place because they sometimes refused personal care. This told staff to work in twos and 'approach [the person] in a calm manner' and explain that they needed assistance. If the person refused staff were advised to try again 20 minutes later. The risk assessment had been drawn up in conjunction with the person's CPN (community psychiatric nurse) who was to be contacted if the person completely declined personal care. The risk assessment had been reviewed regularly and included ABC charts (an observational tool that enable staff to record information about a particular behaviour) to assist staff in choosing the best time to offer personal care. This helped to ensure the person received appropriate care and support safely and when they needed it.

People using the service told us there were enough staff on duty to keep them safe and meet their needs. One person said, "There's plenty of staff and you just have to ask if you need them. They are nice and helpful."

During our inspection staff were always available to assist people. When people were sitting in the various lounges there was always at least one staff member in attendance. Throughout the day we observed that when call bells were activated staff responded to them quickly.

The service employed both care staff and qualified nurses. The rota showed there was always at least one nurse on duty on each shift. This helped to ensure that people's nursing needs could be met at all times. The nurse led a team of skilled and experienced care staff who were employed in sufficient numbers to meet people's needs promptly.

Records showed that staffing levels were satisfactory and consistent and the staff members we spoke with confirmed this. Staff said they were happy with how many staff were on duty for each shift. One staff member said, "We have enough staff, there are always nurses and carers on duty and people don't have to wait too long if they need staff to help them."

The provider operated a safe recruitment process to help ensure the staff employed had the right skills and experience and were safe to work with the people using the service. We checked two staff files and found they had all the required documentation in place including police checks and references.

People and relatives told us medicines were well-managed at the service and given to people safety and on time. One person told us, "They (staff) are good with medicines."

Since we last inspected management had introduced a new medicines system at the service. This was computerised and supplied by the service's contract pharmacist. It meant that each person had a single electronic medication profile including PRN (as required) medicines. Staff told us this system simplified medicines management for them and made it easier to monitor the effectiveness of people's medicines regimes. Staff were competent in the use of this system and were able to explain to us how it worked and demonstrated its safety and effectiveness.

Medicines were kept securely at all times. We observed two medicines rounds, one carried out by a nurse

and another by a senior carer. We saw that medicines were given safely and on time. Staff explained to people what their medicines were for before administration and people were supported to take their medicines in their own time with a drink of their choice where applicable.

Records showed that the service's contract pharmacist carried out a 'pharmacist advice visit' prior to our inspection visit when they checked the service's policies and procedures, ordering and receipt of medicines, storage of medicines, disposal of medicines, medicines optimisation, records, and staff training. The resulting report showed that no urgent, serious and/or safeguarding issues were identified and the contract pharmacist was satisfied overall that medicines were safely managed at the service.

Good

Is the service effective?

Our findings

People told us the staff were well-trained and had the knowledge and skills they needed to work at the service. One person said, "They [the staff] know what they are doing." A relative commented, "The staff look after people very well and help them."

During our inspection visit we observed staff providing people with effective care. For example, if people were being assisted to move about the premises staff used the correct moving and handling equipment to do this safely and respectfully. One staff member told us, "I was trained in moving and handling when I first came to work here and have had more training since. We have to be careful moving people so they don't get injured and so they feel comfortable when we are using the hoist."

Records showed all staff had had an induction followed by training in a wide range of general and service-specific courses including moving and handling, food hygiene, safeguarding, whistleblowing and dementia care. The provider and manager supported nursing staff to undertake ongoing training in order to remain registered with the NMC (Nursing and Midwifery Council).

The manager told us all training was ongoing to help ensure staff kept their skills and knowledge up to date. Staff had recently attended training courses in male and female catheterisation, and in promoting positive behaviour which included diversion/distraction techniques, engaging people living with dementia and the legal status of restraint. All the staff we spoke with said they were satisfied with the training they'd received and if there was anything they weren't clear about they would discuss it with the manager or one of the nurses.

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 provider's policy 'Consent to Care and Treatment' explained staff responsibilities under the MCA and DoLS. Staff were trained in the principles of the MCA and DoLS and understood the importance of gaining consent before providing people with care and support. All the people using the service had been assessed for their capacity to make decisions. Some people had DoLS authorisations in place due to occasionally resisting personal care and/or being under continual supervision at times. This helped to ensure that any restriction they were subject to were lawful and in their best interests.

We looked how staff supported people to eat and drink enough and maintain a balanced diet. All the people

we spoke with said they liked the food served. The kitchen staff prepared a wide range of cuisine to ensure people's dietary needs were met. They catered for Asian vegetarian, halal and non-halal, English, diabetic, and soft diets. We saw there were jugs of fresh water in all communal areas to encourage people to drink fluids to protect themselves from dehydration.

We observed the lunchtime meal being served. People chose where they wanted to sit and were offered aprons to keep their clothes clean. Asian dishes were served on a traditional stainless steel platters and English food on plates. Food was pureed for those on soft diets and well-presented to ensure it looked appetising. If people needed assistance to eat staff provided this in a kind, unhurried way while making conversation with them. People were given second helpings if they wanted them. Most people ate all of their meals and there were hardly any leftovers. The atmosphere at lunch time was homely and convivial.

We visited the kitchen where all staff and visitors wore wear protective aprons to comply with food hygiene recommendations. We spoke with the cook who was knowledgeable about people's dietary needs and the different diets they required. In the fridge we noticed that some food items had not been dated on opening (margarine, a jar of marmalade, tomato ketchup and a small jar of tuna paste). This meant it would be difficult for staff to ascertain their use-by or sell-by dates. We reported this to the cook who agreed to ensure that in future these types of food items would be dated when they were first opened to ensure the food served was always fit to consume.

Records showed that people's dietary needs were assessed when they came to the service. Each person had an eating and drinking profile which included nutritional assessments, care plans, risk assessments, a list of their dietary preferences, and information on any input from dieticians or the SALT (speech and language therapy) team who advised on choking prevention.

If people needed their weight monitoring they were weighed regularly and staff used a MUST (malnutrition universal screening tool) to estimate what their ideal weight should be. This helped to ensure that staff were able to provide effective support to people at risk of malnutrition or dehydration and refer them for specialist support where necessary.

People told us their healthcare needs were met at the service. One person said, "I've kept my old doctor because they know me well so there are no problems." Another person told us staff supported them to attend hospital appointments when they needed to. A relative said staff ensured their family member saw the GP if they were ill. A local GP provided a surgery at the service once a week so people who wanted to could have appointments with them.

People's healthcare needs were assessed when they came to the service. People had access to a range of healthcare professionals including GPs, mental health practitioners, district nurses, chiropodists, opticians, and dentists. If staff were concerned about a person's health they discussed it with them and their relatives, where appropriate, and referred them to healthcare professionals if required.

Records showed that staff at the service worked closely with local healthcare professionals to ensure people's needs were met. For example, an occupational therapist from a mental health team had recently come to the service to assess one person whose behaviour could be challenging at times. They had advised staff on how best to support this person using activities to promote their well-being. This helped to ensure the person received effective care.

Good

Is the service caring?

Our findings

All the people using the service and relatives we spoke with said the staff were caring and kind. One person told us, "The carers are lovely and they are ever so friendly." Another person commented, "The carers are like my family because they call me 'auntie' [a respectful form of address in this person's culture] and look after me so well." A relative said, "I really like this care home and find the staff to be very caring."

During our inspection we observed many caring interactions between staff and the people they supported. We saw one staff member assisting a person who had become disorientated in one of the corridors. They held their hand, explained to them where they were, and supported them to one of the lounges where they assisted them to sit down. The staff member then got the person a drink and sat with them providing reassurance until the person became more settled.

We saw another staff member talking with a person about their family and taking an interest in when they were coming to visit. This was another example of a staff member supporting a person in a positive and caring manner.

Relatives told us they were always made welcome when they visited the service. One relative told us, "I can visit whenever I want to. They did extend the visiting hours for us. It used to be 11.00 am to 7.00 pm but now we have 7.00 am to midnight." Staff told us that visiting hours had been extended and people's relatives and friends could come to the service whenever they wanted.

Since we last inspected care plans had been personalised and a new section added called 'Life history – this is me'. The manager told us staff liaised with the people using the service and/or their families to complete this. Staff said this information helped them to get to know people and gave them ideas for topics of conversation they could use when they spent time with people.

People using the service spoke a range of languages including Gujarati, Hindi, English, Punjabi and Urdu. All staff spoke English and most spoke some Asian languages. During our inspection visit we observed staff talking with and reading to people in their first languages. This was an example of staff using their language skills to communicate with and build relationships with the people they supported.

However we did see two members of staff to talking to each other in a language that the person they were supporting did not understand. This could be confusing and isolating for the person. We reported this to the manager who agreed to address this.

People were supported to express their views and be actively involved in making decisions about their care and support. Records showed that people and relatives had been consulted when people were assessed to come to the service and when care plans and risk assessments were written. During our inspection visit we observed that staff encouraged people to make choices about all aspects of their day including meals, activities, and when they wanted personal care.

People's privacy and dignity was respected and promoted. People had their own rooms which were decorated for them before they came to the service. One relative told us, "They [the staff] decorated the room ready for my relative to move into." They could also personalise them and bring their own furniture and decorations if they wanted too. This meant that people had their own private space and staff respected this. We observed that staff always knocked on people's doors before entering their rooms.

Good

Is the service responsive?

Our findings

People told us the staff provided them with personalised care. One person said, "The staff know me know and know what I need." Another person commented, "The staff help me get up and go to bed and have a shower." A visiting social care professional told us staff followed expert advice to ensure they were responsive to people's needs.

We looked a care records to see how staff provided responsive care. When people were first referred to the service staff wrote an assessment of their needs in the form of an initial care plan. This meant staff had the basic information they needed about the person when they began supporting them. Records showed that this initial care plan was then used as a basis for further, more detailed care plans.

Staff were familiar with the information in people's care plans. One staff member told us, "If someone new comes to the home we read their care plans so we know how to support them. And we read them again if they are changed. The manager reminds us to do this." Staff were able to tell us how they supported people in line with their preferences. They knew people well and this helped to ensure they provided them with responsive care and support. Care plans were regularly reviewed to take into account people's changing needs.

We observed the afternoon 'handover'. This is a meeting between two shifts to pass on information about people's needs. The handovers at the service were led by the nurses and there were three handovers every 24 hours. Staff updated their colleagues on issues like people's wound care and tissue viability. The handover we witnessed was informative and helped to ensure staff provided people with ongoing responsive care. Staff told us that handovers were essential to the way they communicated information to each other. One staff member said, "If there are any changes to people's needs we discuss them at handover. Today one person's heel looked sore so we told the nurses and then discussed it at handover."

In the morning we didn't see any organised activities taking place, although staff did sit and socialise with people and their relatives. In the afternoon a group of people listened to Hindu music and then staff read to them from a Hindu religious booklet. They then talked amongst themselves discussing what had been read to them. We could see that people had enjoyed this activity and taken an active part in it.

Other faiths were also catered for at the service. For example, a forthcoming Christian event, with visiting representatives of a particular church, was advertised on the noticeboard. The manager told us that if people wanted to go to a place of worship, for example a temple, mosque or church, staff would take them.

The service had two television lounges, one showed English programmes and the other showed Indian programmes. Bollywood and English films were shown once a month. People had been on trips out to a Leicester park and a shopping centre. One person went to a local library regularly with staff.

The manager told us the service usually had two part-time activity co-ordinators but one had just left and they were advertising for a replacement. In the meantime the manager had increased the hours of the

remaining activity co-ordinator so people would not miss out on activities. Records showed that regular activities included beauty treatments, bhajans (Hindi devotional songs), arts and crafts, exercise classes, and storytelling and discussions in different languages.

The provider's complaints procedure gave people information on how they could complain about the service if they wanted to. This was given to people and their representatives when they first came to the service. The complaints procedure was in need of updating to better explain the role of the local authority, the Ombudsman, and CQC in dealing with complaints. The manager agreed to do this.

Records showed that any complaints received were documented and action taken to investigate and resolve them. The manager then wrote to complainants explaining what had been done to address their concerns. This showed the manager was responsive if people made a complaint.

Requires Improvement

Is the service well-led?

Our findings

People told us they were satisfied with the service. One person said, "I wouldn't change anything. I can see my family when I want to and the food is good." A relative told us, "I would rate here as 9 out of 10." A staff member said they would be happy to recommend the service to any of their family members.

People, relatives and staff all appeared to get on well with each other and there was sense of community spirit at the service. For example, we sat and talked with a group of six people and a member of staff in the dining room. They welcomed us to join them and we asked them questions about living at the service which the member of staff translated for us into the language the people preferred. There was lots of laughter and positive comments and all the people in the group told us they thought Rushey Mead Manor was a nice place to live. We also met a person who was new to service and we saw they were happy and smiling and appeared settled.

People and relatives told us the culture at the service was open and friendly and the manager and staff were always available if anyone needed to talk with them. At the time of our inspection visit the manager had been in charge of the service since June 2016 and had applied to CQC to become registered. People told us the manager was hard working and committed to providing good quality care.

The manager told us residents and relatives meetings had been tried in 2016 but had been unsuccessful due to poor attendance. However staff met with people in small groups and on a one-to-one basic to discuss the service. The manager said she talked with all the people and visiting relatives every day to get their views. One relative told us, "I see the manager here seven days a week." People told us the manager often sat with them, shared sweets, and asked how they were and what they thought of the service. Staff told us people looked forward to seeing the manager and some saw her as 'like a daughter' to them.

Staff told us the manager was supportive, had an 'open door' policy, and they could approach her at any time for advice. Records showed staff had regular supervisions, appraisals, meetings, and training opportunities. The care co-ordinator told us communication and teamwork was good at the service. They said they had recently attended a course on leadership to enhance their management skills. The lead nurse, who took responsibility for the service when the manager was not at work, said senior staff had regular managers' meetings to discuss how well the service was performing.

Improvements to the service since we last inspected included new-style handover meetings using improved documentation, a new conservatory, a new medicines system, and more personalised care plans. This showed senior staff had a commitment to ongoing improvement at the service.

At the time of our inspection visit the premises were undergoing major refurbishment throughout. Some areas had been redecorated with 'dementia friendly' contrasting doors, walls and handrails, to make it easier for people to orientate themselves. However some areas of the premises needed more immediate attention.

The ground floor second lounge, which people weren't using although the door was unlocked, had a worn and stained carpet. The easy chairs in this room were also worn and stained, and a side table was wobbly and unsafe. We brought this to the attention of the manager who said this room was due to be refurbished. Approximately one hour later we found the room had been locked and a sign on the door said 'Closed for Refurbishment'. This showed the manger had responded promptly to our concerns about this room.

Other areas of the premises were also in need of attention. A display of pictures showing life in the 1940's in India and Britain were faded and positioned high on the wall which made them difficult to see. The temperature in the conservatory needed monitoring as this room was so warm that one person using this area attempted to remove their upper clothes. The raised plant beds in the gardens didn't appear to have been prepared for spring. There was some builder's debris remaining in the garden from when the conservatory was built.

Improvements were also needed to housekeeping at the service. In the laundry room we saw overflowing bins of dirty washing alongside clean washing. In an upstairs bathroom the floor and bath needed cleaning, the pedal bin was broken, and the radiator didn't have a cover. At the end of the car park towards the kitchen we saw a large bin with the lid open. The bin was overflowing with rubbish, including blue disposable gloves. In addition the medicines trolley handles were broken and the trolley had grease patches on it. There were cobwebs evident in many parts of the premises.

We discussed these issues with the manager. She said she was aware that improvements were needed to the premises and believed the refurbishment programme would address many of these. However she accepted that routine maintenance and housekeeping needed to be more effective to ensure the environment was satisfactory in the meantime. She said she would carry out an audit of the premises to identify what needed doing and then ensure it was done.

Local authority commissioners had also informed us the service was not complying with health and safety legislation as they were using a refurbished part of the building without the required health and safety documentation in place, including a revised water risk assessment. We discussed this with the manager who told us this issue had already been addressed, the required documentation was in place, and the commissioners were returning to the service the following week to check this.

We looked at how the provider ensured the service was delivering good quality care. The provider and the provider's clinical lead visited the service at least weekly on both an announced and an unannounced basis and at different times of the day and night to carry out quality checks. Where improvements were needed the clinical lead produced action plans for the manager to follow, however these did not appear to have identified the issues with the premises that we identified.

CQC records showed that the providers had notified us about certain changes, events and incidents affecting the service or the people using it. However, prior to our inspection, the local authority informed us that one person had had two falls and neither of these had been reported to themselves or CQC. We discussed this with the manager who said they were working with the local authority to look into and resolve this issue.