Perfect Care Limited

Belmont Grange Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 4 and 7 December 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Belmont Grange Nursing and Residential Home provides personal and nursing care for up to 30 older people. On the day of our inspection there were 27 people using the service. This was made up of 22 permanent residents, one respite and four Intermediate Care Plus clients. Intermediate Care Plus (ICP) is a range of health and social care services. The benefits of ICP include preventing inappropriate hospital admissions, promoting faster recovery from illness or injury and providing care at, or close to, home.The registered manager told us permanent beds at the home were full and there was a waiting list for permanent admissions.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

Belmont Grange Nursing and Residential Home was last inspected by CQC on 2 June 2014 and was compliant.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Thorough investigations had been carried out in response to safeguarding incidents or allegations.

People were not protected against the risks associated with the unsafe use and management of medicines.

Staff training was not up to date and staff did not receive regular supervisions and appraisals.

The home was clean and suitable for the people who used the service.

People were protected from the risk of poor nutrition.

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 provider was working within the principles of the MCA.

People who used the service, and family members, were complimentary about the standard of care at Belmont Grange Nursing and Residential Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

We saw that the home had a full programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Belmont Grange Nursing and Residential Home however care plans were not written in a person centred way and some care records were inconsistently completed.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider did not have a robust quality assurance system in place.

The service had good links with the local community.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not protected against the risks associated with the unsafe use and management of medicines.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Thorough investigations had been carried out in response to safeguarding incidents or allegations.

Requires improvement

Is the service effective?
The service was not always effective.

Staff training was not up to date and staff did not receive regular supervisions and appraisals.

People were protected from the risk of poor nutrition.

The provider was working within the principles of the Mental Capacity Act.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with dignity and respect.

People were encouraged to be independent and care for themselves where possible.

People were well presented and staff talked with people in a polite and respectful manner.

Good

Is the service responsive?
The service was not always responsive.

Some care records were inconsistently completed.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints policy and complaints were fully investigated. People who used the service knew how to make a complaint.

Requires improvement

Is the service well-led?
The service was not always well led.

The provider did not have a robust quality assurance system in place.

Requires improvement

Summary of findings

Staff told us the registered manager was approachable and they felt supported in their role.

The service had good links with the local community.

Belmont Grange Nursing and Residential 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 4 and 7 December 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector and a specialist advisor in nursing took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff and infection control team. No concerns were raised by any of these professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with four people who used the service and one family member. We also spoke with the registered manager, a nurse, two care staff, the cook and a visiting health care professional.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Requires improvement

Is the service safe?

Our findings

People we spoke with, and their family members, told us they felt safe at Belmont Grange Nursing and Residential Home. They told us, “Oh yes” and “Yes, she’s safe here”. However, we found people were not protected against the risks associated with the unsafe use and management of medicines.

We looked at the way medicines were managed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. However, we were unable to see regular audits of controlled drugs. Systems were in place to ensure that the medicines had been ordered, stored, administered and counts of ‘when required’ (PRN) medicines were undertaken at each administration. Staff showed us how unwanted or out-of date medicines were disposed of, however we saw that the disposal book was signed by one person and was not countersigned by another appropriate member of staff.

Medicines were securely stored in a locked treatment room. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people’s medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. However, we did not see dated photographs of each person attached to their MARs, to ensure there were no mistakes of identity when administering medicines.The registered manager explained to us following the inspection that this was because all Intermediate Care Plus clients had an identification bracelet completed on admission rather than a photograph. This had been risk assessed and was in place due to the turn over and length of stay of those temporary clients and others being admitted out of hours and staying short periods of time. The person dispensing medicines would cross reference the name, age, date of birth and allergies with the MAR and the information on the bracelet.

Refrigerator temperatures were monitored and recorded together with the room temperature. The ‘minimum’ and the ‘maximum’ refrigerator temperatures had been recorded however we did not see a record of the ‘current’ temperatures, together with the refrigerator being ‘re-set’. We also saw that on three dates in March 2015 refrigerator temperatures had been recorded above eight degrees centigrade and there was no record of the reasons that may have contributed to these high readings, together with the action taken. Room temperatures had been inconsistently recorded during November 2015 and on three dates there were no readings recorded. The nurse reassured us that they would address this immediately. Refrigerator and treatment room temperatures need to be recorded to make sure medicines were stored within the recommended temperature ranges. This meant that the quality of medicines may have been compromised, as they had not been stored under required conditions.

We saw written guidance was kept with the medicines administration records (MAR) charts for the use of PRN medicines however we were unable to see for two people when and how these medicines should be administered to people who needed them, such as for pain relief. This meant that there was limited written guidance for the use of PRN medicines and staff may not be provided with a consistent approach to the administration of this type of medicine.

We also saw incomplete instructions for the use of topical medicines and an absence of body maps for topical medicines application records, together with inconsistent recording of the application of such topical medicines.

This meant people were not protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Requires improvement

Is the service safe?

Through our observations and discussions with the registered manager and staff members we found there were enough staff with the right experience, skills and knowledge to meet the needs of the people living at Belmont Grange Nursing and Residential Home. We observed sufficient numbers of staff on duty, care was not rushed and call bells were answered in a timely manner. We asked staff whether there were plenty of staff on duty. They told us staffing was "Ok" and agency staff were "Rarely used". People we spoke with did not raise any concerns about staffing levels. The registered manager told us they had not used agency care staff for over 18 months but had used agency nurses who were familiar with the home. They also told us staffing levels were reviewed when people's dependency needs changed. This meant sufficient staff were on duty to keep people who used the service safe.

The home is a two storey building set in its own grounds. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean and suitable for the people who used the service. We saw domestic style radiators had guards and window restrictors, which looked to be in good condition, were fitted in the rooms we looked in.

We saw hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

We saw Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. These were in place to give staff specific guidance and instructions about a person's mobility and assistance required in case of an evacuation of the home.

We saw risk assessments were in place and up to date and included profiling beds, use of hoists, passenger lift, kitchen equipment, food temperatures and laundry.

Equipment was in place to meet people's needs including hoists, pressure relief mattresses, shower chairs, wheelchairs and pressure cushions. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire risk assessments were in place and fire safety checks were up to date. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy and procedure and the home used the local authority safeguarding adults risk threshold tool. We looked at the safeguarding file and saw records of safeguarding incidents. The most recent incident occurred in November 2015 and we saw the local authority safeguarding team and GP had been informed. The incident had been investigated and action taken, including supervisions carried out with staff involved.

We looked at accident and incident records and saw each accident and incident had been thoroughly recorded, including when and where the accident occurred, how it occurred, what action was taken, whether an investigation took place and recommendations to prevent a re-occurrence. We saw monthly analysis took place of accidents and incidents and we saw from the analysis carried out in November 2015 that one person who used the service had fallen several times since admission. We saw the person had been referred to the falls clinic at the local hospital and a re-assessment was booked for 8 December 2015. Records we looked at confirmed that falls risk assessments had been undertaken. This meant accidents and incidents, including safeguarding incidents, were dealt with appropriately.

Requires improvement

Is the service effective?

Our findings

People who lived at Belmont Grange Nursing and Residential Home did not always receive effective care and support from well trained and well supported staff.

We saw a copy of the training matrix and saw mandatory training included health and safety, fire awareness, infection control, first aid, control of substances hazardous to health (COSHH), moving and handling, food hygiene, safeguarding, mental capacity and medicines. Staff we spoke with told us they had received "Lots of training" and the deputy manager had provided specific training to members of staff who had not worked in a nursing home before on managing wounds and pressure ulcers. We also saw new staff completed a five day induction to the home.

We looked at the training records for three members of staff and found certificates for two members which were up to date however we could not find training certificates for the third member of staff. We discussed this with the registered manager who was unable to confirm the training dates for this member of staff.

We looked at whether staff had received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We saw that two members of staff had received supervisions however we could not find any records for the third member of staff. We also could not find appraisal records for any of the staff members. We discussed this with the registered manager who told us they could not find any records of staff appraisals and it had been discussed at a management meeting in October that supervisions and appraisals were not being regularly carried out. It was agreed at the meeting that a new process would be implemented for supervisions and appraisals, which involved each member of staff having a designated supervisor and each member of staff receiving an appraisal, four supervisions plus two direct observations per year.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a choice of food and drink throughout the day and we observed staff supporting people in the main dining room at lunch time. We also saw people were supported to eat in their own bedrooms if they preferred. We observed staff offering people a choice of food. The majority of people were able to feed themselves however we observed a member of staff ask a person if they wanted assistance cutting their food, which they accepted. The home used pre-cooked and then frozen food from a supplier for the majority of the meals. Most people told us the food was good however one person told us they were not happy with the quality of the food at the home. We discussed this with their relative who told us it wasn't what the person was used to. The cook told us most people were happy with the food however several alternatives were offered if people did not want what was on the menu. We also saw a regular food questionnaire was carried out to identify what food people liked and disliked.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. We saw a nutrition care plan for a person which said to monitor the person's weight weekly, and we saw that this had been done, and since the person's weight had increased and stabilised, the person was now being weighed monthly.

A choking risk assessment was used to identify specific risks associated with people's eating and drinking and where people were identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts. The food charts were used to record the amount of food a person was taking each day. We saw people's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals, such as GPs, dietitians and speech and language therapists.

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.

Requires improvement

Is the service effective?

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. We saw that DoLS applications had been submitted to the local authority and the registered manager understood their responsibilities with regard to DoLS. This meant the provider was following the requirements in the DoLS.

Mental Capacity Assessment records we looked at confirmed that, where necessary, assessments had been undertaken of people's capacity to make particular decisions. We also saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them. Consent to care and treatment records were signed by people where they were able and if they were unable to sign a relative or representative had signed for them.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. However, for one person we saw the previous care home address crossed out and the current care home address documented. This was actioned during our inspection visit.

We saw Emergency Health Care plans (EHCP), which showed that the relevant people were involved in decisions about a person's end of life choices and EHCPs were in place to anticipate any emergency health problems.

Communication care plans were in place for people. We saw one person's plan stated, "Talk to [Name] to find out why they are anxious or distressed, ensure [Name] has plenty of reassurance from staff, maintain a quiet environment, allow time for [Name] to express their feelings and worries". This meant clear guidance was provided for staff about what actions they should take when the person became agitated or upset.

People's records showed details of appointments with, and visits by, health and social care professionals and we saw evidence that staff had worked with various agencies and made sure people accessed services in cases of emergency, or when people's needs had changed. For example, GP, community matron, dietitian and speech and language therapists (SALT). Care plans reflected the advice and guidance provided by external health and social care professionals. Four people received a visit from a community matron on the day of the inspection, which we were told was part of an ongoing treatment and care plan. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Belmont Grange Nursing and Residential Home. They told us, "The girls are lovely", "Very caring", "They really care", "I have never been so well looked after" and "They [Staff] are lovely".

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. All the staff on duty that we spoke with were able to describe the individual needs of people who used the service and how they wanted and needed to be supported.

We saw people were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people's individual needs. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Oh yes", "Very private" and "Yes, no problems". This meant that staff treated people with dignity and respect.

People told us they could choose where to eat meals and whether to take part in activities. One person told us, "It's my own choice" and "I like to have breakfast in my room".

We observed staff assisting people to mobilise around the home. This was done in a calm and unhurried manner. We observed a member of staff ask a person if they wanted help to sit in an armchair in the lounge. The person said they could manage so the member of staff observed but did not assist. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

We saw the bedrooms were individualised, some with people's own furniture and personal possessions. All the people we spoke with told us they could have visitors whenever they wanted.

We looked at care records and saw people's social profiles contained limited information about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. Although staff we spoke with knew the individual care and support needs of people, records we looked at contained little evidence to show that the person and family members had been involved in care planning and the care plan documentation was not signed by the person or family member. However, we saw the home's activities coordinator had written an 'Activity log' with the person who used the service to identify what they liked to do, whether they had an assessed need for a particular type of activity, the aim of the activity and instructions for staff. We saw staff were instructed to respect people's wishes if they did not want to join in with a particular activity. People and family members we spoke with told us they were involved in, and consulted about, their wishes and interests however not all the records showed this.

We saw people were involved in making decisions about the home, food and activities. The registered manager had introduced a 'Chat room' meeting for people who used the service and family members. This took place fortnightly with tea, coffee and cakes being served and gave people the opportunity to talk about relevant topics, such as Christmas, share things about themselves, reminisce and discuss future activities and events. The registered manager told us a cook/recipe book had been developed from recollections people had provided during these meetings.

Requires improvement

Is the service responsive?

Our findings

The service was not responsive. We saw that care records were inconsistently completed.

We saw that an initial assessment was carried out for each person and care plans were developed detailing people's care needs and support however these were limited in content and we were unable to see records confirming that dependency assessments were carried out for people. We spoke with the nurse who confirmed this. However, we did see that care plans were reviewed monthly and on a more regular basis if necessary, and were reflective of the care being given and reflective of change.

Assessments had been carried out which showed people were at risk of developing pressure ulcers. However, for one person we saw there was inconsistent completion of moving and turning charts and body maps to monitor their care in this area. The care plan for this person stated positional changes should be documented on a positional chart, staff to be observant for any changes and evaluate weekly. However, we were unable to see a wound assessment chart completed to evaluate the type and size of the wound and were unable to see a body map or photograph of the wound. This meant that some care records were not kept up to date and did not reflect the actions detailed in the care plans. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition however these appeared to be focused more on task completion rather than the person's activities and interests. Handover records were used to highlight key information related to people's care and staff we spoke with were knowledgeable about people's care and support needs.

We saw continence assessments were completed and care plans detailed the recommended incontinence products that people should use. Elimination records were also completed to monitor bladder and bowel movements. People's needs were clearly identified and specific plans for supporting people with their mobility needs and transfers were in place and regularly reviewed.

Records we looked at confirmed the level of support people required to maintain personal hygiene. An example for one person stated, "Bed bathing daily, skin condition to be observed any breaks bruising redness etc. to be documented on body map and nurse in charge informed, document when prescribed creams are used."

We spoke with a visiting community matron who told us the home provided, "Spot on care" and "They do refer immediately and they do what they're supposed to do". They also told us, "The manager is very keen on multi-disciplinary team working, staff are proactive, the staff and carers are good and staff know what they're doing."

An activities coordinator was employed three days per week and on other days, activities were carried out by care staff. Activities at the home included pet therapy visits, quizzes, bingo, board games and movies. Local groups visited the home, such as the local church and schools, and people were able to go out on day trips. We asked people if there was much to do at the home. They told us, "I'm happy watching TV and playing bingo" and "No complaints".

We saw copies of the provider's 'Complaints, compliments and suggestions policy' were kept in a file in each person's room, as well as a form that could be completed to raise a complaint. We looked at the complaints file, which included copies of complaints, statements and correspondence with complainants. The most recent complaint was made in May 2015 and we saw how the complaint was responded to, what actions were taken and correspondence with the complainant. People we spoke with were aware of the complaints policy but did not have any complaints about the service. This meant the provider had an effective complaints procedure in place.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. They told us the registered manager was, “Approachable” and “Very nice and supportive”.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The registered manager told us the provider regularly visited the home but these visits were not documented so could not provide any evidence of what was discussed or carried out at these visits. The registered manager told us they carried out regular checks of the home and nurses did daily walkarounds but none of this information was recorded. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some records of recent audits carried out at the home. These included a maintenance audit carried out in November 2015, a kitchen audit carried out in October 2015 and a monthly medicines audit, most recently carried out in November 2015.

We saw staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff meetings, which were held regularly, and agenda items included documentation, teamwork, rotas, holidays, training and new appointments. We also saw the minutes from nurses meetings held in September and October 2015, which included discussions on nurse responsibilities, DoLS, person centred care, medicines, supervisions and staffing.

We saw a copy of a staff survey carried out in November and December 2015. This survey focused on ‘Caring’ and asked staff whether they agreed with various statements, for example, whether people were treated with kindness and compassion, whether staff were trained in equality and diversity and whether staff respected people’s dignity.

We saw people who used the service and visitors were also asked to complete a similar survey approximately every eight weeks and each survey was based on one of the five CQC areas. We saw two recent surveys completed by visiting health care professionals. Comments included, “Staff are friendly and approachable” and “Belmont Grange has a fantastic manager and most staff are also very approachable and helpful”. No concerns were noted in the survey responses. The registered manager told us the surveys were used to identify any common themes or concerns, such as staffing or activities, and actions were put in place for any identified issues.

We saw the registered manager held monthly meetings on the last Wednesday of every month with people who used the service and discussed any news, new appointments and suggestions for activities. This meant people who used the service, family members, visitors and staff were regularly consulted about the quality of the service.

The service had good links with the local community. These included the local church café and coffee morning, visits by the community police and police dog, visits by the local Scouts group and school children. The registered manager told us a local school had raised money for the home and the school children were bringing Christmas gifts to the home on 18 December. We saw the home also hosted harvest festivals and Christmas events.

This meant that the provider gathered information about the quality of their service from a variety of sources however did not have a robust quality assurance process in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Accurate, complete and contemporaneous records in respect of each service user were not being maintained. Regulation 17(2)(c). The quality and safety of the services provided was not being assessed or monitored. Regulation 17(2)(a).