Pride Care Homes Limited Liability Partnership

The Malting's Care 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

The Malting's Care Home is registered to provide nursing and personal care for up to 50 people, some of whom live with dementia. The home, which is located close to Peterborough, is arranged on two floors. The first floor is accessed by stairs or lifts. There is an enclosed garden to the rear. On-site facilities include a gym and cinema. At the time of our visit there were 49 people using the service.

This comprehensive inspection took place on 2 February 2016 and was unannounced. At the last inspection on 18 May 2015 we asked the provider to take action to make improvements regarding the display of our judgement ratings and this action was completed. A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed and medicines were safely managed.

People were supported to eat and drink sufficient amounts of food and drink and there were choices of food from what was on the main menu. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was acting in accordance with the requirements of the MCA so that people had their rights protected by the law.
Assessments were in place to determine if people had the capacity to make decisions in relation to their care. When people were assessed to lack capacity, their care was provided in their best interests. In addition, the provider had notified the responsible authorities when some of the people had restrictions imposed on them for safety reasons. The provider was meeting the conditions of people's authorised DoLS applications.

People were looked after by staff who were trained and supported to do their job.

People were supported by kind, respectful and attentive staff. Relatives were given opportunities to be involved in the review of their family members' individual care plans.

People were supported with a range of hobbies and interests that took part in and out of the home. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened and responded to.

The provider had not submitted notifications as they were required to when people's DoLS applications were authorised. This omission had reduced the provider's ability to demonstrate that they operated a transparent culture as part of their duty of candour. The registered manager was supported by a team of managerial, care and ancillary staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Since our last inspection of 18 May 2015 improvements had been made in relation to the displaying of our judgement ratings within the home and on the provider's website. Quality monitoring procedures were in place and action had been taken where improvements were identified.

We found the provider was in breach of a regulation in relation to submission of notifications regarding people's authorised DoLS. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were treated well and were looked after by a sufficient number of well-recruited staff to meet their individual needs.

People were enabled to take risks and measures were in place to minimise these risks.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were trained and supported to do their job.

The provider was following the principles of the Mental Capacity Act 2005 and protected people's rights in making decisions about their day-to-day living.

People's nutritional, physical and mental health was maintained.

Is the service caring?

Good

The service was caring.

People were enabled to be involved in making decisions about their care.

Staff supported people to maintain their dignity and independence.

People were looked after by kind and caring members of staff.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People were enabled to take part in a range of activities that were important to them.

There was a complaints procedure in place and the provider responded to people's concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not submitted required notifications and, therefore, had reduced their ability to demonstrate that they operated an open and transparent culture.

People and staff were enabled to make suggestions to improve the quality of the care provided.

Quality assurance systems were in place to monitor and review the standard and safety of people's care.

The Malting's Care 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 was carried out on 2 February 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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 the inspection we spoke with eight people; three relatives; the Nominated Individual [a named person representing the registered provider]; two registered nurses; a senior carer supervisor; a senior carer; two members of care staff. We also spoke with an activities co-ordinator; a member of the catering staff and a visiting health care professional. We observed care to help us with our understanding of how people were looked after. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care records, medicines administration records and records in relation to the management of staff and management of the service.

Good

Is the service safe?

Our findings

People told us that they were treated well and this had made them feel safe. One person said, "I feel very contented and comfortable being here." Another person added that that they felt safe because of the security of the building. Relatives told us that they felt their family member was safe because members of staff made them to feel comfortable and got on well with them.

There were procedures in place to minimise the risks of harm to people. This included the training of staff in protecting people from such risks. Members of care staff told us what they would do if they suspected people were being placed at any risk of harm or actual harm. This included the reporting the incident to their [registered] manager and if they needed to, they would report their concerns to the police and local authority. In addition to this, members of staff were aware of the signs and symptoms to look out for if someone was being harmed. One member of care staff said, "You can see how a person is feeling; any differences in their behaviour; changes in their habits. Bruising (of their skin)." A member of the senior care team also described similar signs and symptoms of what to look out for when a person was placed at risk or experienced harm. The provider had taken the appropriate actions when there had been any safeguarding concerns that had been raised. The actions included reporting to the local safeguarding authority.

The provider told us in their PIR that there were recruitment systems in place. This was to ensure that all checks were carried out before prospective employees were deemed suitable to do the job that they had applied for. Members of staff confirmed this was the case. One member of care staff said, "I filled out an application form; had a DBS (Disclosure and Barring Service) check and two written references as well." They told us that they had attended a face-to-face interview during which they answered questions about their previous experiences. Another member of care staff said, "There was an application form. I filled this out. I was booked in and went for an interview. I had a DBS check. To check I didn't have any criminal record. Two written references (were obtained) from my previous employers."

People told us that there was sufficient numbers of staff to look after them. One person said that they felt safe because, "There is always someone [staff] around day and night." People said that the staff came when they called them for assistance and, usually, without a delay. One person told us that sometimes the staff response times varied, depending on how "busy staff are." We observed staff at work and also timed their response to people's calls for assistance. We found that people's calls were attended to within less than five minutes. A visiting health care professional and relatives told us that they had no concerns about staffing numbers.

A member of senior care staff said, "We do have enough staff. Staff are quite good in covering for other staff (who were not able to work)." They also told us that, since the home had opened in 2014, there was less reliance on staff who were working in the provider's other 'sister' homes, to cover staff absences at The Malting's Care Home. This was confirmed by the Nominated Individual (NI). As a result of a stable team of staff, the member of senior care staff told us that this had helped with improving the continuity of people's care. They also told us that they felt the way people were looked after was also more organised with a stable team of staff. We found that people's needs were met in an unhurried way. This included assistance to eat

and drink and to take their medicines as prescribed.

Risk assessments were in place to minimise the risks to people during their everyday living and activities. Members of staff were aware of people's risks. One member of senior care staff said, "If someone goes out to the shops, there are risks there. They could be involved in an (traffic) accident. Or be robbed. We need to do a risk assessment to identify the risk and if we can prevent (or reduce) the risks. We put measures in place to prevent them. And make sure the person is aware of the risks." People's risks to their health were assessed and measures were in place to manage the risks. These included, for example, risks of choking and development of pressure ulcers. Measures were in place which included soft diets and thickened drinks and the provision of pressure-relieving aids, respectively. Measures were in place to minimise the risk associated with the use of moving and handling equipment. We saw that two members of staff supported a person to safely transfer by means of moving and handling equipment.

Relatives told us that they were satisfied with how their family member was assisted with taking their medicines to help ease their discomfort. People also told us that they were satisfied with how they were assisted to take their medicines as prescribed. One person said, "They [staff] bring them (medicines) to me. I don't have to ask." Another person told us that they were enabled to manage their own medicines and kept these in their room, which we saw was locked. They said, "I always lock my room. I read the instructions in the box of tablets and read how to take them (tablets)." They also told us that the registered manager had re-assessed them to ensure that they continued to be safe in doing so.

Medicines administration records showed that people were given their medicines as prescribed. We saw people were given time to safely swallow their medicines and no medicines were unsafely left out for people to take later. Medicines were stored safely and managed by staff who were trained and assessed to be competent to do so. One registered nurse told us that the registered manager had watched them assist people with their medicines and they were assessed to be competent in doing so. Audits had been carried out in relation to the management of medicines and action was taken to improve the management of people's medicines. This included, for instance, recording the quantity of 'variable' doses (one or two tablets to be taken) and ensuring that the medicines trollies were kept secure when they were not in use. Other actions taken included maintaining complete and accurate medicines administration records and ensuring that people's prescribed medicines were always available. One person told us that staff had made sure that they had always had enough of their prescribed medicines to take. A member of senior care staff told us how they made sure that there was always enough stock levels of medicines available. They said, "I always make sure that when we are on the second to last week (of the medicines' cycle), I order more (medicines)."

Good

Is the service effective?

Our findings

One person told us that they were satisfied and confident in the staff's abilities to help them with their moving and handling needs. They said "They [staff] know what they are doing."

Members of staff told us that they had attended training, which included induction training. One member of care staff said, "I had induction training. Three days. I 'shadowed' a senior carer and worked alongside them." Another member of care staff also told us that their induction training included watching and being observed by senior members of care staff. There was a system in place during which new staff had to satisfactorily complete their three-month probationary period. This was before they were allowed to continue their employment.

The provider told us in their provider information return (PIR) that staff had attended training in a range of topics. Staff confirmed this was the case and told us that they had attended a range of training. This included health and safety, safeguarding people at risk, the application of the Mental Capacity Act 2005 (MCA) and looking after people with behaviours that challenge. Staff training records confirmed this was the case. A registered nurse told us that they felt that they did not have the knowledge to effectively care for people who had mental health needs. However, they were, aware that future training was planned in relation to this area of care.

Staff told us that they had benefited from their training. A registered nurse told us that they had a better understanding of DoLS. They said, "The DoLS (training) told us what it is for and why we are applying (for it). For example, if a person has been assessed to come into the home and they may be deprived of leaving the premises (for justified safety reasons)." Members of staff had some knowledge regarding the MCA. One member of care staff said, "It (the MCA) is about the right of a person to make decisions unless a person does not have the capacity to make the 'right' decisions." A senior member of care staff expanded on this and said, "You may have people who may not have mental capacity, but they can still make decisions about some things. And it can change any time." They gave the example of people developing dementia and how this affects people's ability to continue to make decisions they could make before developing the condition.

Members of care staff told us that they felt supported to do their job and some had experiences of previous employment to compare with their current one. A registered nurse said, "I feel less stress (working here) as the floor (people's care and activities) are managed well. Because we work well as a team." They also told us that the management team were supportive and said, "They are always looking out for you." A senior member of care staff said, "When you talk to your [registered] manager, they listen to you. They actually do what you have suggested." They gave an example of how they were supported in managing members of care staff who they were responsible for. Members of staff said that they had attended one-to-one supervision and this was mainly observation of their work. A senior member of care staff told us that this supervision had enabled staff to receive feedback about their work and were informed of any improvements they may need to make.

The 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 found that people's mental capacity to make decisions about their care was formally assessed and, where they lacked capacity, their care was carried out in their 'best interest' to keep them safe and well. This included, for example, supporting people to eat and drink suitable foods, to be assisted with their personal care and helped to take their prescribed medicines. In addition to 'best interest' supported decision making procedures, there were procedures in place to support people in their decisions about end-of-life care. When the person lacked the capacity to make such decisions, they were supported with this by a member of the medical profession and a close relative. Furthermore, DoLS applications had been made and those that were authorised were in date. Staff followed the conditions of the authorised DoLS as an integral part of caring for people as part of the 'best interest' decision approach.

People told us that they always had enough to eat and drink and their records demonstrated that the amounts of what they had taken were recorded. One person said their lunch was "very tasty" and told us that they had enough to eat. We saw that staff assisted people with their eating and drinking when they were unable to independently do this. People were encouraged and prompted to eat their food and were asked if they wanted anymore.

People told us that they were able to choose an alternative meal, if they did not want to eat what was on the menu. A member of the catering staff confirmed this was the case and gave examples of this. This included offering alternatives of salad and chicken. People were provided with food to meet their dietary and cultural needs, which included vegetarian and soft or pureed food. Nutritional supplements were available to maintain and promote people's nutritional health. These included milkshakes and prescribed nutritional drinks.

People's nutritional and swallowing risks were assessed and action was taken when the risks identified action was to be taken. This included assisting people to access dietary advice from dieticians and speech and language therapists respectively. People were also weighed and the frequency of this depended on the outcome of their nutritional risks. We found that people's weights were stable: this indicated that the actions taken were effective in maintaining people's nutritional health.

People were looked after in a way that maintained their health and well-being. Relatives told us that they were very satisfied with how their family member was looked after. They said that they had noticed an improvement in their family member's overall condition. This included the healing of their pressure ulcers (which had been acquired before the person had moved into the home).

Care records demonstrated that people's health risks were assessed and measures were in place to manage the risks. These included the provision of moving and handling equipment and bed rails to minimise the risk of people from falling; the provision of pressure-relieving equipment and care of people's skin to minimise the risk of people acquiring pressure ulcers. Records, which included management audit records, showed that people's pressure ulcers were healing in response to the treatment and care people had received.

People told us that they had been seen by a GP when they needed to be treated. One person also said, "I haven't needed to see a GP, but they [staff] would get me one if I needed one." We saw a member of nursing

staff make a telephone request to a GP on behalf of a person who felt unwell. People's care records showed that people had access to a range of health care professionals which included tissue viability and continence assessment nurses. On the day of our visit some of the people were treated by chiropodists, one of whom told us that they visited the home to treat people every six weeks.

The home offered on-site exercise facilities and activities. One person said that they enjoyed exercising in the gym, where they would take part in activities to keep the strength in their upper body and arms. They said that this had helped them stay independent with moving and repositioning themselves when in bed.

Good

Is the service caring?

Our findings

People said that they were treated well. One person said, "I'm very contented. Very peaceful (being) here." Relatives said that the staff treated their family member in a respectful and warm way. They said, "They [staff] laugh with [family member] and put [family member] at ease." They also told us that they and their family member were treated as individuals. One of the relatives said, "They [staff] treat you here as a human being."

The provider told us in their PIR that they had received 20 written compliments, some of which were 'thank you' cards from people's relatives'. One of these read, "Thank you for all the care, help and friendship you have shown us whilst [family member] was a resident [people who live in the home] with you." Another 'thank you' card read, "Thank you for the wonderful care you gave [family member]. You gave [family member] dignity, but also gave [family member] comfort."

We saw that people were treated by patient staff when they assisted people with their prescribed medicines and with eating and drinking. We also saw that staff talked to people when they walked alongside them and also responded to their request for assistance during lunch time. There were other examples of good care that people received. We saw that staff members crouched down and were at eye level with people when they spoke with them. In addition, members of staff touched and held people in a respectful and comforting way.

People told us that their choices of how they wanted to be looked after were respected. One person aid that they got up and went to bed and this was, "agreeable on both sides" (an agreement between them and care staff). Another person told us that they were involved in discussing their care needs and that their choices were taken into account.

Relatives' told us that they were kept involved in supporting their family member's planned care and the reviews of this. They said that they were aware of when the review meeting was due to take place. People told us that they were asked about their care on a more informal basis. One person said that the registered manager regularly visited them and asked them about their care and any concerns they may have had about it.

People were supported to maintain contact with friends and families. We saw people had their relatives visiting them, in the privacy of their own room or in the communal lounges. People and relatives told us that there were no restrictions on visiting times.

People's privacy and dignity were respected as all bedrooms were used for single occupancy and toilet and bathing facilities were provided with lockable doors. Members of staff were aware of respecting people's privacy; they provided people with their personal care behind closed doors. A visiting health care professional confirmed this was the case. They also told us that they treated people in the privacy of their individual bedrooms. We saw that people's clothing was kept clean from the spillage of drink and food by means of wearing appropriate cloth tabards.

People's independence was maintained and promoted with their personal care, medicines, walking and eating and drinking. One person said, "I'm still doing my own medicines." Another person described how members of care staff helped them with areas of personal care; this was only when the person was not able to independently manage these areas. We saw that people were encouraged to be independent with their walking with the provision of walking aids. We also saw that people were encouraged to be independent with eating and drinking and were assisted by members of staff only when they were not able to do so.

Members of care staff had an understanding of the principles of caring for people who they looked after. One member of care staff said, "You finish your day and (you know) you have done something important to help someone feel better." A member of senior care staff expanded on this and said, "(My job) is to make sure people are happy. Their wishes are respected. (For them) to be able to choose the care they want and how they want it. If they want a female [carer] then they have the right to refuse a male carer." They also told us that their job was to promote people's privacy and independence and gave satisfactory examples of how this was achieved. This included making sure that people were kept covered up as much as possible when they were assisted with their personal care.

Information about advocacy services was publicly available in the main reception area of the home and also kept in people's individual care files. Advocates are people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People told us that the staff knew them as individuals and that they knew them. One person told us "definitely" staff knew them as a person and showed that they knew the names of individual care staff who looked after them. One relative said, "[Family member] knows the staff. [Family member] recognises their faces." They added that members of care staff knew how to manage their family member's behaviours. They told us that this had promoted a positive change in their family member's demeanour to become more settled.

People's needs were assessed before moving into the home to make sure that their individual needs would be met. The pre-admission assessment involved the person, their family member and health and social care professionals. The pre-admission assessments provided a base for the development of people's care plans. People's care plans and risk assessments were reviewed and kept up-to-date to provide staff with the guidance in how to meet the people's individual needs. A member of senior care staff said, "We review the care plans every four weeks. Or sooner." Short term care plans were developed to provide staff with the guidance in how to meet the changes in people's needs. This included, for instance, a change in a person's breathing and the treatment of a chest infection and the steps to take to improve the person's health.

Information about people's life histories was recorded and recreational activities were aimed to meet people's past interests. These included the use of soft toys, shopping and taking exercise. The activities co-ordinator advised us that there was a range of activities that people had taken part in. These included a summer barbeque; Christmas' celebrations; fireworks and sensory activities to stimulate people's smell, taste and sound and to experience new sensations. On-site facilities included a gym and cinema which enabled people to exercise and watch films, respectively. One person told us that they never got bored and chose to stay in their room and records confirmed that people's choices, in relation to taking part in activities, were respected.

People's cultural beliefs were valued. The provider wrote in their PIR that halal and vegetarian diets were catered for. People were also enabled to follow their beliefs and had attended services that took place in the home, which were held by different religious organisations.

People told us that they knew how to make a complaint. One person said, "I'd speak to [name of registered manager]." Another person said, "Whatever you tell them [members of the management team] they put it right." Relatives were aware of who they would speak with if they wanted to raise a concern or make a complaint but said that they were very satisfied with how their family member was looked after. Members of staff were aware of supporting people to make a complaint and told us that this would be by following the provider's complaint procedure. One member of care staff said, "I would try (initially) to find out about the complaint and then direct them [the complainant] to the [registered] manager." A member of senior care staff said, "I would listen to the person [complainant] and I would always put it (complaint) in the 'book'. This would then be dealt with by my [registered] manager."

The provider told us in their PIR that they had received two complaints within the last 12 months and these

had been responded to within 28-days. The management team and record of complaints confirmed this was the case and actions were taken to the satisfaction of all parties involved.

Requires Improvement

Is the service well-led?

Our findings

The provider told us in their PIR that some of the people had authorised DoLS applications. Information we hold about the home showed that we had not received the required notifications to inform us that the DoLS applications had been authorised. In four of the people's records we found applications for DoLS, which included an urgent DoLS application, had been authorised. One registered nurse and a senior member of care staff confirmed that this was the case. The NI told us that no required notifications had been submitted to the Care Quality Commission (CQC) in relation to authorised DoLS applications. This omission had reduced the provider's ability to demonstrate that they operated a transparent culture as part of their duty of candour.

This was a breach of the Regulation 18 (4) (a) (b) (c) (d) of the Care Quality Commission (Registration) Regulations 2009.

There was a manager in post and they were registered with the Care Quality Commission on 22 December 2015. They were a registered nurse and had previous experience in managing care homes. The registered manager was supported by a small number of teams. These included senior management teams and teams of care and ancillary staff, which included catering, activities and domestic staff. We received positive comments about the registered manager who was often described as being "approachable." People and visitors told us that they knew who the registered manager was and also knew of individual members of the senior management team.

Following our focused unannounced inspection of 18 May 2015, the provider wrote to tell us, on 15 June 2015, what they were going to do to meet the requirements of Regulation 20A. They told us that they planned to take action which would meet the requirements of Regulation 20A by no later than 31 July 2015. Before the inspection of 2 February 2016 we checked the provider's website and found that information about our judgment ratings of The Maltings Care Home was available for the public to see. In addition, during our inspection we found on entry to the home that this information was also in a public area. This was in view for people, which included staff and visitors, who entered the home to see.

The provider had a training plan in place to ensure that members of staff knowledge and skills were kept up-to-date and to provide people with care to meet their needs in a safe and appropriate way. The training plan showed that arrangements were made for staff to attend training in a number of topics. These included, for example, the application of MCA and DoLS, end of life care, management of diabetes, dementia and behaviours that challenge and moving and handling. The NI advised us that, as part of improving the quality of people's care arrangements were in place for all staff to attend current and future training by an external trainer. The training included, for example, equality and diversity.

Audits had been carried out in relation to, for instance, the safety of moving and handling equipment; complaints; safety and cleanliness of the premises and people's care records. Action plans were made to improve any deficits or shortfalls which were identified during the audits. The action plans detailed the named staff member who was responsible for the areas for improvement and the date of when the actions

were to be completed. The provider had a system in place to check the progress of the completion of the actions and this was risk based according to the progression of the actions. The senior management team kept this under review as part of the quality monitoring system.

Other audits were carried out by an independent consultant who advised the provider of actions that were needed to be taken to improve the safety and quality of people's care. The audits covered a range of topics, which included record keeping, the quality of staff engagement with people they looked after and management of people's medicines. The provider had taken action and work was also in progress in response to the findings of the audit.

People were enabled to make suggestions and comments about their support and care on a daily and informal basis. Meetings had been held during 2015 during which people made comments and suggestions about the range of activities. As part of an improvement strategy, there were arrangements in place for people's meetings to be held on a more frequent basis; there were set dates of when these were to take place during 2016.

Members of staff were also enabled to make suggestions and comments during meetings held on a regular basis. One member of care staff suggested improvements in infection control procedures and said that these were now in place. They said, "It was quite good to be heard. You feel good about it." One registered nurse told us that they found the meetings were "informative." A member of senior care staff told us that there were also 'mini meetings' during which staff's work performances were sometimes discussed. Action was taken to increase the level of observation of identified staff members at work. The senior member of care staff said, "I observe them [members of care staff] and check how they are working." They told us that their observations were fed back to the observed member of care staff and any improvements were identified. The senior member of care staff said, "(The feedback maybe to) give the member of care staff a different idea (of doing things)."

The staff meetings also enabled the provider to remind staff of their roles and responsibilities in making sure that people were provided with safe and appropriate care. This included, for instance, making sure that people's nutritional needs were being met and that their care and medicines records were completed in an accurate way.

Members of staff were aware of the whistleblowing policy and told us that they would have no reservations in blowing the whistle. A senior member of care staff said, "If I saw a carer harming a resident, I would go to my [registered] manager and if nothing is done, I would report to the CQC and the local authority." A member of care staff said, "If I saw any abuse, I would report it straight away to my [registered] manager."

Links were made with the local community. People were assisted to access local shops and take part in activities organised by a local religious organisation. During Christmas time, school children attended the home and sang carols as part of the arranged activities within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications to the Care Quality Commission following authorisation of Deprivation of Liberty Safeguard applications. Regulation 18 (4) (a) (b) (c) (d) of the Care Quality Commission (Registration) Regulations 2009.