Bupa Care Homes (CFChomes) Limited

The Red House Residential and Nursing Home

Inspection report

Bury Road
Ramsey
Cambridgeshire
PE26 1NA

Tel: 01487898106

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Red House Residential and Nursing Home is registered to provide accommodation, personal and nursing care for up to 60 people. The home is located in a residential area of the fenland market town of Ramsey. Short and long term stays are offered. At the time of our inspection there were 55 people living at the home.

This comprehensive inspection took place on 8 March 2016 and was unannounced.

A registered manager was in post at the time of our inspection and had been registered since 9 November 2015. 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.

Staff were knowledgeable about identifying and reporting any incident of harm that people may experience. People were looked after by enough staff to support them with their individual needs. Measures were in place to cover staff absence and there was monitoring of sickness levels of individual members of staff. Satisfactory pre-employment checks were completed on staff before they were allowed look after people who used the service. People were supported to take their medicines as prescribed and medicines were safely managed.

People had sufficient amounts of food and drink. People were offered choices of food and drink and people liked the choices that were available. They were also supported to access a range of health care services and their individual health needs were met.

People's rights in making decisions and suggestions in relation to their support and care were respected. Where people were not able to make such decisions, their needs were met in their best interest.

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

The CQC monitors the operation of the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] which applies to care services. When people were assessed to lack capacity, their care was provided in their best interests. However, DoLS applications had not been made to responsible authorities when some of the people had restrictions imposed on them. Therefore, the provider was not acting in accordance with the requirements of the MCA.

People were treated by kind and attentive staff. They and their relatives were involved in the review of people's individual care plans.

People's care was provided based on their individual needs and they were supported to maintain contact

with their relatives. People were encouraged to take part in a range of hobbies and interests. There was a process in place so that people's concerns and complaints were listened to.

Staff were trained and supported 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. Monitoring procedures were in place to review the standard and quality of people's care.

We found the provider was in breach of one regulation in relation to lack of submission of DoLS applications to the appropriate authorities. 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 looked after by a sufficient number of staff.

Recruitment procedures ensured that people were looked after by staff who were deemed suitable to do the job that they had applied and been accepted for.

People's medicines were handled and managed by staff who were trained to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not consistently following the Mental Capacity Act 2005 which meant that people's rights were not always being protected.

Staff attended training to safely and effectively look after people.

People's physical and nutritional health was maintained.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff.

People's right to privacy and dignity was respected

Staff respected and valued people's decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual health needs were met.

People were provided with a range of activities that took place in

and out of the home.

There was a complaints procedure in place and the provider had taken action to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the progress of staff training to keep people from the risk of unsafe care.

There were auditing procedures in place to analyse information to improve the standard of people's care.

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

The Red House Residential 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 8 March 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we received information from a local contracts officer and we looked at all of the information that we had about the home. 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.

During the inspection we spoke with seven people who used the service, two relatives and a visiting health care professional. We also spoke with the registered manager; one team leader; two senior care staff; three care staff; one registered nurse; one activities co-ordinator; two catering staff and the receptionist. We looked at four people's care records and records in relation to the management of the service and the management of staff. We observed people's care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People told us that they felt safe and gave their reasons for feeling so. One person told us that they felt safe because the staff checked them to see if they were alright. They said, "People [staff] come in here and out a lot." They gave an example of staff checking them to make sure that they had not fallen. Another person said, "I don't feel worried about anything. I'm well looked after."

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. They were able to describe the types of harm and the actions they would take, which included reporting the incident to the police and local authority. The provider had submitted notifications that demonstrated the appropriate actions they had taken to minimise the risk of harm to people. This included minimising the immediate risk and reporting to the local authority.

Recruitment systems were in place 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 described their experience of when they were applying and recruited to the job. One member of senior care staff said, "I had a telephone interview and then a face-to-face interview. I had a full DBS [enhanced Disclosure and Barring Service check].There were at least two [written] references that were needed." One activities co-ordinator also told us about their experience of applying and being recruited to their job. They also added that they had completed an on-line application form. All checks were carried out before staff worked at the home.

We received a range of views from people, relatives and staff we spoke with about staffing numbers. People told us that there was usually enough staff but this varied. One person said, "When I ring the bell at night they [staff] usually do come. It is better at night than at days." However, another person told us that there were enough staff to make sure that they were safe at all times. One member of senior care staff considered there was enough staff to provide people with the care that they needed to be safe. However, they said that there were not enough staff to provide people with quality care. They said, "We don't have time to sit and talk to a resident [person living at the home]." One person also confirmed to us that staff did not have time to sit and talk to them. Another member of senior care staff, however, said, "There is enough staff. We do and can use agency [staff]." member of care staff said, "Normally there is enough staff." A visiting health care professional said, "I would say there is generally enough staff."

Relatives told us that they had concerns about the staffing numbers because they believed their family member was not always getting the care to meet their individual needs. However, we found that people were receiving the care that they needed by sufficient staff. People were supported by the appropriate numbers of staff to ensure that their nutritional, personal care and moving and handling needs were usually met in a timely manner. Notwithstanding this, at the time of our visit the home was undergoing a refurbishment; temporary dining and communal seating arrangements were in place. We saw that some people were sat at the dining room table 30 minutes before they were served their meal. Two people who were living with dementia became unsettled during this time due to this delay. A representative of the registered provider had monitored this situation during their December 2015 visit and found that people

were served their meals without delay. The registered manager considered our findings were attributable to the interim dining arrangements. This view was supported by one senior member of care staff who said, "It's [work] has been a lot worse since refurbishment due to two separate dining rooms at the moment." The registered manager advised us that they would review the time people had to wait for their meals to be served in the dining rooms before any further actions may need to be taken.

There was a system in place to record staff response times to call bells. The records demonstrated that the majority of the time staff had responded to people call bells within less than five minutes. Where there were few exceptions to this, the registered manager told us that they had looked into this and gave justified reasons to explain the findings. This included an increase of call bells being rung during the busy lunch time period. We timed staff response times to people's activated call bells; people's calls for assistance were responded to within less than five minutes.

The registered manager told us that there was active recruitment to fill registered nurse vacancies. Measures were taken to cover staff vacancies and absences. This included the use of agency and bank staff. One agency member of nursing staff told us that they had worked at the home "many times" and demonstrated their awareness of people's individual needs. One member of bank staff told us that they worked during the busier times of the day, which were mid-morning and evening time. The registered manager said that people's needs were reviewed on a daily basis and these were matched against the staffing numbers. This review would entail staff being requested to change their work schedule or work extra hours. One senior member of care staff said that they had worked extra hours to cover staff absence; an agency member of staff said that when there were staff shortages, the registered manager "would call someone [staff member] in later," to cover this shortfall.

One member of senior care staff told us that staffing numbers were affected when staff called in, at short notice, to declare that that they were unable to work due to sickness. The registered manager told us that staff sickness levels were monitored and kept under review. This was to aim for a reduction in the levels of staff sickness, which posed a risk to people's standard of care, due to unplanned staff absences.

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 senior member of care staff said, "Risk assessments would happen if there are any possible risks that is imposed. For example a ramp at the back [of the building] with a non-slip surface." They also told us about managing people's risk of choking with the use of thickening agents added to people's drinks, based on advice from a speech and language therapist [SALT]. People's risk were assessed and measures were in place to minimise the risks. These included the risks of falls and risks of developing pressure ulcers. The measures taken, which included the use of moving and handling and pressure-relieving care, were effective. This was because there was a reduced the number of incidents of people falling and developing pressure ulcers.

People told us that they were satisfied with how their prescribed medicines were managed. Based on the outcome of their risk assessments, people were enabled to be independent with managing their own prescribed medicines. One person said, "I do [manage and take] my own calcium tablets. I also take one capsule and another blue capsule later." Another person told us that they had been responsible in managing their own medicines. However, they said that this was now done by staff. They said, "I thought now is the time I needed to hand over the 'keys'". Other people told us that they were satisfied with how the staff supported them to take their medicines. One person said, "They [staff] come in the morning and every evening and then I take them [prescribed medicines].If I ask for something like paracetamol, I can have it." Another person told us that staff made sure they had safely swallowed their medication. They said, "Staff stand patiently while I take my tablets."

People's records for administration of their medicines showed that people had taken their medicines as prescribed. The registered manager had carried out audits of the medicines records. The audit carried out during February 2016 showed that where deficiencies were identified, remedial action had been taken in response to the findings of the audit. One team leader said, "There were a few signatures that were missing and a couple of protocols for use of lactulose [laxative]. It was all dealt with." We saw an example of a new protocol that was in place for the use of lactulose.

All members of staff responsible in supporting people with taking their prescribed medicines were trained and assessed to be competent to carry out this part of their role. One member of care staff said, "Class room induction training was medication. Then we did practical [training]. I had to be observed three times to show that I was competent to do medicines." The agency member of nursing staff told us that they had been assessed to be competent by the management of the agency who they worked for.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

At the time of our inspection some of the people were assessed to lack capacity. Mental capacity assessments were carried out and people were provided with care, and future care, in their 'best interest'. This included, for example, assistance with their health needs, end-of-life treatment and managing their finances. Staff training records showed that all of the staff had attended training in the application of the MCA. One member of care staff was able to demonstrate their knowledge gained from their training. They said, "[MCA] is when it's to see [assess] if people have mental capacity to make their own decisions. Some people can make day-to-day decisions but can't make formal decisions. For example, have an operation. Then they would have an appointee to help them with [making] a best interest decision." A senior member of care staff showed us that they carried a 'cue' card to refer to in relation to the application of the MCA. The registered manager told us that this was an action taken for all staff to be provided with their own MCA 'cue' card.

We found that there were some restrictions placed on people which restricted their liberty. This included the use of door gates to some of people's bedroom doors to prevent other people from entering uninvited. The registered manager told us that most of the people had given their consent for the use of door gates. However, the registered manager identified two people who lacked capacity to be able to give their consent before their door gates were installed. In addition, some of the people were unable to leave the home unless they were escorted. Furthermore, one person required their nutrition to be taken by artificial means and one team leader told us that a person stayed in their wheelchair for their meal. They said, "[Name of person] likes to walk about. They are in their wheelchair to keep them safe." The registered manager, registered nurse and senior care staff told us that DoLS applications had not been made to the local supervisory body to authorise that these restrictions were lawful, or that their advice had been obtained.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Members of staff said that they had training, which included induction training, to be able to do their job. One senior member of care staff said, "Induction training; that was a week. Four day class room based and one day working at [name of another of the provider' registered care homes]. Class room training included moving and handling, fire safety and medicines." Another member of care staff told us that they had attended refresher training in a range of subjects. The registered manager said, "The refresher training is to test [members of staff] knowledge and has to be 90% pass rate. If they [staff] fail, they have to start the training again."

Staff told us that they felt supported to do their job and had attended supervision sessions. However, one member of care staff was unclear about the frequency of their one-to-one supervisions. The registered manager advised us that both supervision and appraisals of all staff would be completed by no later than 31 March 2016.

People said that they liked the food. One person told us that they had "enjoyed" their lunch of sausages, vegetables and rice pudding. Another person, after eating all of their lunch of chicken and vegetables, said, "I really enjoyed that."

People told us, and we saw, that they always had enough to eat and drink and were able to choose what they wanted. A choice of menu was available and this was presented to people the day before. Catering staff told us that if people did not like their chosen first option, there were opportunities for alternative menu options to choose from. One member of catering staff said, "If the meal is refused, then we 'plate up' another meal. There is extra food prepared to swap it." A 'snack' menu was available for people and we saw that one person requested a milky drink and sandwiches during the night. When people were unable to take their food and drink by mouth, their nutritional and hydration needs were met by means of artificial feeding. People had access to specialist services to maintain their nutritional and hydration needs, which included nutritionists and SALT. When people were assessed to be at risk of under nourishment or were found to have unintentional weight loss, their foods were fortified and nutritional supplements given, which included a variety of flavoured milk shakes.

Information about people's individual dietary needs was obtained and shared with catering staff. One member of catering staff said, "When they [people] come in new [to the home], I ask them what they like and want and I put this on the [notice] board." Information provided on the notice board showed that people's individual dietary needs were catered for. These included, for example, soft and pureed diets and special diets to manage people's health conditions, such as diabetes. The catering staff, however, told us that they had received conflicting information in relation to diets for people living with diabetes. The registered manager advised us that this concern would be addressed in consultation with a nutritionist and members of catering, care and nursing staff.

People said that they had access to GP, district nurses and other health care services. One person said, "I saw the opticians not so long ago [for an eye check]." Another person said that they were able to make their own appointments with the GP practice. The registered manager told us that GPs visited the home and said, "So they see all of the residents [people] at that time." They also said that a chiropodist was due to attend to treat people's feet "in just over a week's time."

People's health and well-being were monitored and reviewed. This included monitoring people who became unsettled and triggers that may have caused incidents. Other health conditions included Parkinson's disease and unintentional weight loss. People had access to Parkinson's disease specialist nursing services and weights were recorded and reviewed respectively. A visiting health care professional told us that, since the change of management of the home, there had been an improvement in how people's health care needs were being met. They said, "[Name of registered manager] wants people to be looked after properly." They gave an example of the improved care of people at risk of developing pressure ulcers and how this had reduced the number of such preventable incidents.

Good

Is the service caring?

Our findings

People had positive comments to make about how staff treated them. One person said "[Name of member of care staff] is marvellous. I'm being looked after very well." Another person said, "The staff are kind. I get a lot of support from them. Kindness is the most important thing."

We saw people were looked after by attentive and patient staff. This included when offering people choices of where they wanted to eat their lunch and during a game of 'bingo'. We also saw staff crouch down and speak with people at eye-level so that the person who was being spoken with would not feel intimidated.

People's preference in how they wanted to be looked after was respected. This included, for example, the preferred gender of the member of care staff. One person said, "A male carer would not be asked to provide me with personal care." Another person also told us that they preferred to have female staff to provide them with personal care and this preference was "always" respected.

People's independence was maintained and promoted with their eating and drinking. Some people were provided with plate guards to enable them to guide their food onto their cutlery. Staff asked people if they wanted their food to be cut up into more manageable bite sized pieces to independently eat. Some people said they wanted this assistance and others said that they were happy to do this for themselves. When people were not able to be independent with eating and drinking, staff supported individual people with this on a one-to-one basis.

Relatives said that they were able to visit every day and we saw people receiving guests in the privacy of the own room or in the communal areas. One relative said, "It's a very friendly home." We saw that some of the people had made friends with other people living in the home.

Members of staff understood the principles of care. One senior member of care staff said, "My job is to ensure that our residents [people] live a healthy and enjoyable life. To promote independence. To make them [people] feel valued as individuals and not labelled all the same." One team leader said, "Residents [people] come first. Make sure they are comfortable and covered up and kept private [when having personal care]. And give them choices. I always ask them what they want to choose to wear. Always ask them what they want." People told us that they could choose what they wanted to wear, when to get up and when to go to bed. 'Privacy' signs were hung outside people's doors when they were receiving personal care and to prevent other people from entering during this time.

People were asked for their choices in relation to the refurbishment of the home. One person told us that they had a say in the colour scheme of their bedroom. The registered manager told us that examples of paint colours were presented to people to choose what they wanted and this included the communal areas of the home.

The premises maximised people's privacy and dignity. All rooms were for single occupancy and the offer of shared rooms was available which included the use of by couples. Toilet and bathing facilities were

provided with lockable doors. There was a range of communal rooms and plans were in place to increase the comfort and purpose of these, as part of the refurbishment of the home. The registered manager told us, based on people's views, there would be individual designated areas for people to watch television, to listen to the radio and make a drink. People were able to personalise their bedrooms with their own possessions, which included ornaments, soft toys and furniture.

Advocates are people who are independent and support people to make and communicate their views and wishes. Advocacy services were in use and these enabled people to be supported in managing their affairs by an independent agent.

Good

Is the service responsive?

Our findings

People told us that the staff knew them as individuals and understood how to meet their needs and knew them as an individual person. Members of management and care staff showed their understanding of people's individual needs and knowledge about people's family relationships.

People's individual needs were met which included continence, hearing and mobility needs. We saw members of care staff helped people to change their continence aids; people had their hearing aids in; equipment was available and trained staff helped people with their moving and handling needs by means of a hoist.

Members of staff were also aware of people's individual communication needs. People were offered choices of what they would like to drink in a way that they could understand. This included providing verbal information in measured way, supported by a visual presentation of three jugs of differently flavoured water. The registered manager advised us that menu options for people to choose from would be presented in picture format, once the refurbishment of the home was completed. However, they said that they would consider alternative methods to improve how those people, who were living with dementia, would be able to choose what they wanted to eat. For instance, from a visual presentation of two choices of plated food which the person would be able to see and smell.

People told us that they had enough to do with how they spent their time. One person said that they enjoyed reading their daily newspaper and watching the television in the privacy of their own room. Another person said that they enjoyed spending time with their relatives who visited each day. They told us that they had opportunities to take part in the arranged activities. One person said that they were looking forward to playing a game of 'bingo', which took place every Tuesday afternoon. We watched people playing an adapted form of 'bingo'. This was with large playing cards and counters to enable people with seeing and co-ordination needs to take part in the activity.

One activities co-ordinator told us that the range of activities was based on people's life histories and by 'experiment.' They said, "We mainly talk to the residents [people]. Get information also from families [people's relatives] and members of staff. Sometimes it is showing people different things, like printing. It is about building people's confidence [to take part]." They told us how some of the people had gained benefits from taking part in the activities. They said, "One person wasn't very verbal. Now we are having 'full blown' conversations. Another person was encouraged to become more mobile. We do 'The Lambeth Walk' together. The more [person] walks, the more [person] talks. [Person] is more alert. We try and mix and match activities. We have had trips out to the zoo and tea at [name of] garden centre. There is a lot of in-house entertainment. They [people] really, really enjoy it." People who were unable to attend group activities received one-to-one activities, which included nail care and one-to-one conversations.

Care records demonstrated that people's needs were assessed before they moved into the home to ensure that their needs would be met. People, if possible, and their relatives were part of this assessment process. One person said, "Actually, yes, that was so [had been part of their pre-admission assessment.]" People said

that they were also involved in the on-going reviews of their care plans. One person said, "I think they [staff] have gone through my care plan with me." Relatives also told us that they had attended a review of their family member's care plan.

People's individual needs were assessed and these and risk assessments were reviewed at least once a month, if not sooner. In addition to these reviews, daily meetings enabled staff and management teams to review the needs of people.

People told us that they knew how to make a complaint. One person said, "I'd speak to [name of service manager]." Members of staff were also aware of supporting people to make a complaint and told us that this would be following the provider's complaint procedure, if they were unable to address the concerns. The receptionist gave an example of how they had responded to concerns raised in relation to missing laundry items. People's complaints were responded to and dealt with in line with the provider's complaints procedure. Relatives told us that they had recently raised their concerns with the registered manager and were satisfied with the action taken to improve their family member's standard of care.

Good

Is the service well-led?

Our findings

We received positive comments about the leadership style of the registered manager and improvements within the management of the home. A local contracts monitoring officer told us that they had assessed and rated the home to be 'good.' A visiting health care professional said, "[Registered manager] is very approachable. [Registered manager] is doing his job from the right place. He's interested in people's welfare." One person said, "I get on well with [registered manager]." Other people told us that they often saw the registered manager and we saw their presence throughout the home when helping and talking with people and members of staff. Members of staff told us that they found the registered manager to be "approachable."

Staff were enabled to make suggestions in improving the standard of people's care. One activities co-ordinator said that the registered manager would listen to their suggestions which were supported by clear reasons for their suggestions. Staff were also enabled to make recommendations during daily meetings and group meetings. Minutes of the group meetings demonstrated that the registered manager had reminded staff of their roles and responsibilities in providing people with safe care. This included, for example, maintaining up-to-date training and making sure that any changes to their working patterns were approved by the registered manager.

A member of staff said that since the registered manager came in post, "The relatives and people have a lot more input. They had been [previously] told what was happening but now there is more of a discussion." People and their relatives were provided with opportunities to attend meetings. Minutes of the last meeting, which took place during December 2015, showed that attendees discussed agenda items which included the refurbishment of the home, activities and laundry services. Surveys were also carried out to obtain people's views about the home. We compared the results with the survey carried out during May 2015 with those from the results of the survey which carried out in November 2015; these showed an overall increase in the level of satisfaction of the respondents. This included, for example, increased satisfaction levels in the range of activities and quality of food.

Action was taken, based on people's suggestions, to re-introduce a 'key worker' system. [A key worker is a named member of staff linked with a named person they would support]. The registered manager advised us that the re-introduced key worker system was to enable people and relatives to forge relationships with a named key worker. However, their availability to liaise with people's relatives was not always possible, due to staffing arrangements. Other action that was taken - and work was in progress to fully achieve this - was for an improvement in staffing numbers and availability of staff. The registered manager told us that, due to recruitment of new staff, this had reduced the number of agency staff used. In addition, the registered manager considered that improvements in this area would become more noticeable once the refurbishment of the home was completed. This was expected to be during May 2016.

Quality assurance systems were in place and these included a two-way process between the registered manager and the provider's different organisational departments. The provider advised what action was to be taken, if needed, by the registered manager. This included consultation with a falls co-ordinator, to

improve the safety of people. The registered manager told us that information about complaints contributed to the quality assurance system. Emerging trends or themes were considered and action was taken, if needed, in response to the analysis of the information. Other quality assurance systems included monthly visits by a representative of the provider when audits were carried out in a number of areas. Actions were identified and who was responsible to address any deficits and the timescale for when these were to be achieved. The provider's representative reviewed the completion of these actions, which included the appraisal, supervision and training of all staff. The registered manager told us that there was one outstanding action and told us what action was to be taken by whom and the date of when this action was to be completed by. This was in relation to auditing of staff files and this was to be completed by no later than 31 March 2016.

Members of care staff were aware of the whistle blowing procedure and said that they had no reservations in reporting any concerns to the provider or external agencies, such as the local authority. In addition, they gave examples of when they would follow the whistle blowing policy and the protection this gave them and to people they looked after. One member of care staff said, "Whistle blowing is when anything isn't correct. For example, staff not following correct procedures. This is when you report it to your [registered] manager, their manager, CQC [Care Quality Commission] or the local authority."

There was an open culture operating within the home as there were links with the community. Students from a local college had worked during 2015 to help with maintaining the courtyard areas and supporting people with their recreational activities. Also, members from different denominations visited the home; this was to carry out religious services for people to attend if they wanted to. On the day of our inspection a person was visited by a member of their chosen religious denomination to practice their faith.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person was not acting in accordance with the Mental Capacity Act 2005 Regulation 11(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).