The Weir Nursing Home Ltd

The Weir Nursing 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 25 April and 3 May 2018. Day one of the inspection was unannounced, and day two was announced.

The Weir is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service provides accommodation and nursing care for up to 35 people. At the time of this inspection, there were 31 people living at the home, some of whom were living with Parkinson's disease , motor-neurone disease, and dementia.

There was a registered manager in post, who was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of our last inspection undertaken in October 2016, we rated the service as Good. At this inspection, we identified concerns in relation to safe medicine management and the governance in relation to this. The service is now rated Requires Improvement.

Stock balances of medicines had not always been accurately maintained, which meant there were medicines unaccounted for. Where people were prescribed creams, these were not always managed safely, with the wrong creams found in people's bedrooms. As prescribed creams and liquid medicine did not have opening dates on, we could not be assured medicine in use was within its shelf-life period.

Language and terminology used in people's care plans and on staff notice boards was not always in keeping with the principles of the Mental Capacity Act. Whilst no unlawful restrictions were in place for people, terminology used did not always reflect this.

Although the registered manager, clinical lead and provider had quality assurance measures in place, these had not identified the shortfalls in medicine administration.

The provider had not assured all relevant notifications had been submitted to the CQC, as required by law. Where there were unexplained injuries to people, the CQC had not always been informed.

There were enough staff to meet people's physical and emotional needs. The provider adhered to safe recruitment procedures.

Safety and maintenance checks were routinely carried out at the home to ensure people's physical environment was safe. People were protected from the risk of infection.

Staff received ongoing training and development in their roles, and this training was also made available to people living at the home, and their relatives.

People were encouraged to maintain their health, and were supported with their eating and drinking needs. Orientation boards were used at the home to help people navigate and to know the date and time.

People enjoyed positive and respectful relationships with staff. People's individual communication needs and styles were known. People had access to independent advocates, as required.

People were encouraged to enjoy a range of social and leisure opportunities. Staff knew people well, both in terms of their health and wellbeing needs, and in relation to their personal preferences. Complaints, feedback and suggestions were acted upon.

People, relatives, staff and health professionals were positive about how the home was run. Staff felt valued and motivated in their roles. People were involved in decisions about the running of their home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Prescribed creams were not always administered or stored safely. Stock balances of medicines contained discrepancies, so it was not always possible to tell whether people had received their medicines.

There were enough staff to meet people's physical and emotional needs. People were protected from the risk of infection, and were safeguarded from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Language and terminology used was not always in keeping with the principles of the Mental Capacity Act.

People had access to healthcare professionals and were supported to maintain their health. People enjoyed nutritious meals, and received the help they needed with their eating and drinking needs. Staff received ongoing training and support to enable them to be effective in their roles.

Is the service caring?

Good

The service was caring.

People's individual communication styles were known and understood by staff. People's independence was promoted.

People's dignity was maintained, and staff were respectful in their approach.

Is the service responsive?

Good

The service was responsive.

People were able to enjoy their hobbies and interests, as well as develop new ones. Staff understood people's personal preferences and respected these.

There was a system in place for capturing and responding to complaints, comments, feedback and suggestions.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Medication audits had not identified all of the shortfalls identified during the course of the inspection. The CQC had not always been informed by the provider of notifiable events.

There was an inclusive and calm environment within the home. Staff felt valued and respected, and committed to their roles. People's feedback was sought on the running of the home, and this was acted on.

The Weir 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.

The inspection was prompted in part by notification of an incident where a person who had fallen seriously injured themselves during an extended power cut at The Weir. The information shared with CQC about the incident indicated potential concerns about the provider's contingency planning for power failures at the home, particularly in relation to emergency lighting. This inspection examined those risks.

This inspection took place on 25 April and 3 May 2018. Day one of the inspection was unannounced, and day two was announced.

Day one of this inspection was completed by two inspectors, a specialist nurse adviser, and an expert-by-experience. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two was conducted by two inspectors.

We reviewed information we held about the service. We looked at our own system to see if we had received any concerns or compliments about the provider. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We asked the Local Authority for any information they had which would aid our inspection. We used their feedback as part of our planning.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 13 people who lived at the home, and four relatives. We spoke with the registered manager; the provider; the clinical manager; three nurses; a senior nursing assistant; two members of the care staff

team; the cook; and the activities coordinator. We also spoke with a visiting GP and a vicar, and reviewed written feedback from three healthcare professionals. We looked at five care plans, which contained healthcare information; mental capacity assessments; risk assessments; reviews of people's care and pre-admission assessments. We also looked at three staff pre-employment checks; the provider's quality assurance records; medication administration records; cream charts; and complaints, comments and feedback received.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in October 2016, we rated this key question as Good. At this inspection, we found shortfalls in the safe storage and administration of people's medicines, and this key question is now rated Requires Improvement.

We considered whether people's medicines were stored and administered safely. It is good practice to maintain ongoing accurate stock level checks of all medicines within a care home so that adequate stock levels and stock rotation can be maintained and discrepancies or missed doses can be easily identified. This includes not only checking that the correct numbers or volumes of the respective medicines are present, but also that they are within their expiry dates. During the inspection, we were unable to determine whether the stock balances were correct, as accurate records of stock balances had not always been maintained. For example, one person was prescribed an anticoagulant (a blood thinning medicine). The stock balance stated there should be 27 tablets in stock, but there were only 23. Nursing staff told us the initial stock level must have been documented incorrectly, but they were satisfied the person had received their medicine. Another person was prescribed medicine for a bowel complaint, which was prescribed to be administered on alternate days. There were two unaccounted for sachets in the box, but the medicine administration records for the person had been signed for to say the person had received their medicine. We asked the registered manager whether this meant the person's medicine had been signed for and not given, and neither they nor the nursing team were assured the person had received their medicine as prescribed. The registered manager told us this particular medicine had not always been part of the monthly stock take, but it would now be counted weekly on the medication administration record.

Some people's medicines had been prescribed on a PRN basis ('as required'). However, there were no PRN protocols in place to inform staff as to when the medicines should be offered or administered. For example, one person had been prescribed pain relief 'as required.' There was no protocol in place regarding how this person may express pain and when pain relief should be offered. Furthermore, there were no pain monitoring tools in place to assess whether the pain relief had been effective. We spoke with the nurse on duty and the clinical manager, who ensured pain monitoring tools and PRN protocols were in place by the second day of our inspection. The registered manager told us, "This is partly down to complacency; we know our residents so well."

Where people had been prescribed creams for skin conditions, these were not always stored or administered safely. For example, one person was prescribed an antiseptic cream. However, the 'cream chart' in their bedroom referred to the application of a different type of cream (an emollient), which was kept in their bedroom. We found a further instance during our inspection of an incorrect cream in a person's bedroom. This placed people at risk of not having the correct prescribed cream applied. We brought this to the attention of the registered manager and the lead nurse that day, who ensured the cream was removed and cream chart was updated. We reviewed a sample of other cream charts and found these did not contain information for staff about where the creams were to be applied, or how often. We raised this with the registered manager, and updated cream charts were in place by the second day of our inspection.

Prescribed creams did not have an opening date on them, contrary to good practice. It is important an accurate date of opening is recorded, as some creams have a specific shelf life. For example, one cream had been dispensed to the home in September 2017 and had a shelf life of three months. This cream was open and being used to treat the person's skin condition. However, staff were not able to tell us whether the cream had passed the recommended three months. The registered manager told us they and the clinical lead would review people's prescribed creams and ensure that these were stored and administered safely. They accepted this was poor practice, and that prescribed creams should be treated with the same diligence as any other prescribed medicine. Following our inspection, the registered manager told us they had audited all the other prescribed creams and found one more which was out of date; this cream was discarded and replaced. All the other creams were checked and found to be within date.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their role and responsibilities in regard to protecting people from abuse and harm, and they had received training in safeguarding. However, during our inspection, we saw in one person's care plan there had been recent concerns about a person returning to The Weir from hospital with extensive unexplained bruising to their legs. The clinical manager had documented the concern in the person's care plan and taken photographs of the injuries, but had not notified the relevant authorities, including the CQC. The CQC requires providers to notify them of any allegations of abuse or suspected abuse, as well as any serious injuries people sustain. We spoke with the registered manager, who told us, "On reflection, I probably should have raised a safeguarding concern about this as we have done in the past where something similar has occurred." The registered manager told us they would now report any concerns of this nature to the authorities.

There were enough staff on duty to meet people's physical safety and emotional needs. The registered manager told us the provider ensured there were 10% more staff on duty than was required, to ensure staffing levels were always at a consistently high level. Staff rotas we saw confirmed this. People and relatives told us they had no concerns about the staffing levels at The Weir. One person we spoke with told us, "All the nurses have the time to listen to you." A relative we spoke with told us, "There are enough staff and they all know what they are doing." Agency staff were not used, which meant people were cared for by a consistent and regular staff team.

Before prospective staff started work at The Weir, they were subject to reference checks and checks with the Disclosure and Barring Service ("DBS"). DBS checks are used to vet staff and prevent unsuitable people from working in care. The provider and the registered manager had processes in place to investigate and address any concerns about staff conduct, which included taking disciplinary action, where needed.

People were protected from the risk of infection. Cleaning schedules were in place, and adhered to, and infection control checks were carried out routinely to monitor the cleanliness of the home. Health professionals and visitors we spoke with all commented on the cleanliness of the home and the lack of any malodours. During the course of our inspection, worn carpet was replaced and new carpet fitted, which had been scheduled for completion prior to our inspection. At the time of our inspection The Weir had a current food hygiene rating of five stars, awarded by the Food Standards Agency.

The provider monitored the safety of the premises for people, as well as the ongoing safety of the equipment used. We saw measures were in place, such as quarterly external tests of the emergency lighting. Fire safety measures were also in place, and each person living at The Weir had their own individual personal evacuation plan in the event of an emergency. Where unexpected events had occurred within the home,

lessons had been learnt in order to take further steps to ensure people's safety. For example, following a lengthy power failure at the home during recent adverse weather conditions, the provider had reviewed their emergency policy and made changes to the action staff must take where a power cut lasts three hours or longer. The provider had also replaced all the emergency torches at the home, and weekly checks were carried out on these to ensure they remained charged.

Risk assessments were in place in relation to people's individual care and support needs. For example, we saw risk assessments in areas such as swallowing, mobility and people's mental health needs. One person's reflection caused them distress at times, and so measures were in place to monitor this person's wellbeing and ensure mirrors in the person's room were covered. The clinical lead had introduced the 'safety cross' tool for falls monitoring. This is a data collection tool, which is recognised by the National Institute for Health and Care Excellence ("NICE"). This tool was being used to monitor trends in people's falls and look at whether there had been any increases in the amount. The data was then used to look at what action should be taken, such as referrals to physiotherapists or GPs. We also found best practice was being followed in relation to neurological observations after falls and suspected head injuries.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in October 2016, we rated this key question as Good. At this inspection, we found language and terminology used by the provider was not always in keeping with the principles of the Mental Capacity Act. This key question is now rated Requires Improvement.

We looked at whether people's rights were protected under the Mental Capacity Act. 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.

Prior to our inspection, we received information of concern about the provider restricting health professionals' access to one person living at the home. We considered this matter during our inspection, and whilst we found no such restrictions were in place, the language and terminology used by the provider in the person's care plan and on staff notice boards were not in keeping with the principles of the MCA. For example, the person's care plan stated, "Please do not allow any external professionals – doctors, nurses, DoLS Assessors etc, to speak with [person] without authorisation from [the provider, clinical lead or registered manager]." The person in question had, at that time, been assessed as having capacity and therefore, would not require anyone to 'authorise' their visitors. The provider explained their intention was to protect the person from undue anxiety and upset, as they suffered from mental health difficulties, and unexpected visitors was a trigger for this. During our inspection, the provider removed any wording which may read as restrictive, and put a protocol in place in regard to managing the person's anxiety, which was shared with all relevant health professionals involved in the person's care.

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 provider was working within the principles of the MCA. At the time of our inspection, only one person living at The Weir had an authorised DoLS, but the registered manager had ensured all DoLS applications had been submitted, where appropriate.

Staff we spoke with had an understanding of the MCA and how it underpinned their practice. For example, staff understood people may have capacity in some areas, but not all. They also understood capacity may fluctuate, and so should be reviewed as people's needs change. Staff were also aware who had an authorised DoLS in place, and what these restrictions meant for the person. Where people lacked capacity to make decisions about their care and support, decisions had been made in their best interests. These decisions were made by the provider, family members and health care professionals, and were kept under review. People we spoke with confirmed they were offered choices by staff. One person we spoke with told us, "They [staff] take note of our choice; they don't force you."

People and relatives told us they felt staff were competent in their roles. One person we spoke with told us,

"They [staff] know what they are doing." A relative we spoke with told us, "The medical side is superb. You can't find fault." We saw examples of where staff were working within current best medical practice. For example, we found an effective system in place for neurological observations following a fall, and suspected head injuries.

Staff received ongoing support, training and development in their roles. One member of staff we spoke with told us, "I have supervision with the registered manager regularly. We talk about everything, including training needs." Another member of staff told us, "I think I do get enough training for my role. I get supervision every six months with the manager. Any issues are addressed with the manager , who listens." We saw staff had access to a range of training, and all their training was up-to-date. Areas staff received training in included equality and diversity; dementia; stroke awareness; diabetes; and falls prevention. This training was also made available to people living at The Weir, as well as their relatives. We saw instances of where people living at the home had taken part in their training, and also where relatives had provided positive feedback about training they had undertaken at the home. The registered manager told us there was a strong focus at The Weir on personal and professional development, and continual learning.

People had access to a range of healthcare professionals, including opticians, GPs, physiotherapists and specialist nurses. People told us they saw healthcare professionals, as and when needed, and there was never a delay in appointments being made for them. Care plans we looked at confirmed this, A visiting healthcare professional we spoke with told us staff were very good at highlighting concerns, were knowledgeable about people's needs, and were efficient at ongoing health monitoring.

People told us they enjoyed the choice and variety of home-cooked meals available. One person told us, " It [the food] is always delicious, and there is something different every day." Another person told us they appreciated the fact the food was all prepared onsite and told us they could taste the difference. Where people needed support with eating and drinking, this was provided. One person we spoke with told us, "I have trouble eating, but my food is mashed for me." We spoke with the cook, who demonstrated a good understanding of people's individual dietary requirements and preferences. Where there were concerns about people's swallowing or eating needs, referrals had been made to the speech and language therapy team, and their recommendations implemented. We saw swallowing care plans had been implemented for people on thickened fluids. Staff we spoke with knew about people's swallowing care plans and what their support needs were.

During the course of our inspection, we saw people were able to navigate their way around the home. 'Orientation boards' were in place, which are a recognised tool to assist people who are living with dementia. The boards contained information about what day of the week it was and what the weather is like. We also saw clear signage around the home to help people find their way to their bedroom or dining room.

Good

Is the service caring?

Our findings

At our previous inspection in October 2016, we rated this key question as Good. At thus inspection, we found this key question remained Good.

People and relatives told us they were happy with the caring approach of staff. One person we spoke with told us, "They [staff] look after me nicely. There are nurses available 24 hours' a day, which is excellent." Another person told us, "I am very happy here and would not like to leave. If I want personal things doing, they [staff] do it all for you." Relatives we spoke with praised the way staff maintained people's personal appearance and gave consideration to how people would like to dress, whether they would like to wear make-up and so forth. One relative we spoke with told us, "It makes my day to see my [relative] smiling, and always clean and smart. I know they are very safe here and being cared for, one hundred percent." Another relative we spoke with told us, "The staff are wonderful to my [relative]. What they have done for them is wonderful. As a family, we are so happy." Relatives told us there were no restrictions on when they could visit the home, and they were always made to feel welcome. We saw recent feedback from a GP, who had commented, "The Weir provides consistently excellent and professional care to its residents." Other visiting professionals we spoke with during the inspection also spoke highly of the standard of care offered.

People's independence was promoted, as much as possible. One member of staff we spoke with told us, "We encourage people to be independent by making choices, eating and washing themselves, as it is better for their overall wellbeing." We saw examples of how independence was promoted. One person was partially sighted and had been offered assistance in the form of adaptations for the lift, but they had refused this as they said they were able to cope by themselves. The person also liked to walk around the grounds of the home independently, which staff respected but also made sure they kept watch, in case the person was at risk of harm.

People's individual communication styles and preferences were known by staff. One person communicated by hand gestures, which we saw staff understood and used to communicate with this person. Where people had specific communication needs, these were contained in individual communication care plans. People were supported to access independent advocacy services. Independent advocates represent the views of people who may not be able to express themselves, or need support with doing so, and ensure their views are heard when making decisions which affect their care.

Dignity and respect were promoted within the home. The registered manager and a staff member were both 'dignity champions.' A dignity champion educates staff around dignity and respect, challenges any poor practice, and ensures people's human rights are upheld. We saw people being treated with dignity, and that staff were respectful of people's individual needs. For example, staff respected one person's need for privacy in relation to their sexual needs.

Good

Is the service responsive?

Our findings

At our previous inspection in October 2016, we rated this key question as Good. At this inspection, we found this key question retained a rating of Good.

People and their relatives told us they were happy with the range of social and leisure opportunities available at The Weir, and that people were able to enjoy their individual hobbies and interests. One person we spoke with told us, "I like it (living at The Weir). We have choices and there are activities." One relative we spoke with told us how happy they, and their loved one, were that staff had set up and area for the person to continue to enjoy doing art and flower arranging. Another person we spoke with told us staff took them out as much as possible as that is what they enjoyed doing.

The registered manager told us that social interaction and stimulation was a priority at The Weir. There were 80 hours' of in-house activities provided per week, plus a monthly calendar of other activities provided by outside organisations. We looked at a sample of these monthly events and saw people had recently enjoyed a range of social and leisure events, including cheese and wine tasting, an outing to the local cathedral, and a gardening club.

People and relatives we spoke with told us staff were responsive to people's individual needs. One relative we spoke with told us staff were "exceptionally quick" to respond when people were showing signs of distress or discomfort. This was reflected in our observations throughout the inspection. For example, one person complained of pain in their leg, and a member of staff was quick to respond and offer pain relief. We found people's changing health and wellbeing needs were responded to promptly, and that people's care plans and needs were reviewed regularly. People and their relatives told us they were involved in reviews of care plans, which was reflected in the documents we looked at. Care plans contained information about people's personal preferences, interests, likes, dislikes and life histories. Staff we spoke with knew this information about people, and we saw examples of people's preferences being respected. One member of staff told us, "We are here to help people live the life they choose."

At the time of our inspection, there were people living at The Weir who were receiving end-of-life care. Staff we spoke with had received training in this area, including the use of syringe drivers to enable them to administer pain relief; this was administered by nurses. We saw in people's end-of-life care plans their wishes had been discussed with them and their relatives, where appropriate. The Weir had established links with a local hospice, who had also provided training for staff.

We looked at whether the provider was complying with the requirements of the Accessible Information Standard ("AIS"). The AIS places a duty on publically-funded bodies to ensure key information about their service is provided in accessible formats for people who have sensory impairments. We found the provider was working within this requirement. For example, one person living at the home was partially sighted. The registered manager had spoken with the person about making adjustments to the buttons in the lift for them, which the person had refused. People also had access to 'Talking Books' and the registered manager told us information about the service could be provided in audio formats, if required.

There was a system in place for capturing, investigating and responding to complaints, comments, suggestions and feedback. People and relatives told us they knew how to complain to, should the need arise. Where complaints had been received, these had been investigated and responded to. Residents' meetings were used as a way of capturing people's views and suggestions, and we saw these were acted on.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in October 2016, we rated this key question as Good. At this inspection, we found that medication audits were not effective in monitoring the safe administration and storage of people's medicines, and not all relevant statutory notifications had been submitted to the CQC. This key question is now rated Requires Improvement.

Registered providers are required, by law, to notify the CQC when Deprivation of Liberty Safeguards (DoLS) have been authorised for people under their care. During the course of our inspection, we found we had not been notified of one person's authorised DoLS. We spoke with the registered manager, who told us they had been unaware of this requirement, but they would ensure they would submit these notifications to the CQC from now on. The registered manager understood their responsibility in submitting other notifications to the CQC, and were able to demonstrate other notifications had been submitted appropriately, such as death notifications.

The registered manager, clinical lead and provider had systems in place to monitor the quality and safety of care people received. The registered manager carried out regular checks in areas such as dignity and respect, the overall dining experience for people, infection control and safe moving and handling techniques. The registered manager was able to demonstrate to us how these checks and audits were used to improve practice and ensure people received safe care. However, the medication audits had not highlighted all of the concerns we identified during the course of our inspection. We discussed this with the registered manager, who told us the frequency of medication reviews would increase from monthly to fortnightly, with immediate effect. They also told us the medication audit tool would be reviewed to make sure it covered all the necessary areas, such as prescription creams.

People, relatives, health professionals and staff were complimentary about the running of the home. Two people living at the home told us the home was "managed very well." A relative told us, "It [The Weir] seems to run like clockwork. The owner [provider] is very approachable." A visiting health professional described the management of the home as "fantastic", and praised the responsiveness of staff. All the staff we spoke with were motivated in their roles and told us they felt valued. One member of staff told us, "I feel genuinely valued and get the support when I need it. The [registered manager] is wonderful and supports you 200%." The registered manager told us there was an emphasis on valuing and developing staff at The Weir, because, "A happy team is a productive team." We found there was a positive and inclusive atmosphere in the home, where diversity was embraced. For example, a number of staff working at The Weir were not originally from Britain. The provider had placed a large map of staff's country of origin in the staff room, which one staff member told us they appreciated as it made them feel closer to home. This inclusiveness extended to people living at The Weir, and both the provider and the registered manager told us they would welcome people from diverse backgrounds if they wanted to live at The Weir.

At the time of our inspection, the provider was carrying out planned refurbishments to the home, and we saw people and their relatives had been involved in this process. For example, a patio area was being created at the request and suggestion of people and relatives. An additional dining area had also been

created at the request of people living at the home. The registered manager told us their focus was increasing the amount of outings offered to people, such as a forthcoming planned outing to a local butterfly farm. The registered manager told us the provider was "very supportive, and very hands-on." They told us there were never any issues or delays where new equipment was needed, and that the provider was committed to providing a high-quality service to people.

The registered manager kept up-to-date with current best practice by being member of the Registered Nursing Home Association, as well on mailing lists for organisations such as Age Concern. They also kept their own manual handling training certificate up-to-date, to enable them to deliver in-house training to staff, as well as carry out observations of staff practice. The registered manager had a background in advocacy services, which meant they had a particular awareness of the importance of people having access to this type of service., which we saw benefited the people living at The Weir.

Links had been established with the local community for the benefit of people living at The Weir. On the day of our inspection, a scheduled holy communion took place for those who wished to take part, which was carried out by a local vicar. We also saw examples of where people had been supported to enjoy their local pub, or walks outside of the home. On the second day of our inspection, we saw people were taken out to visit a garden centre.

The provider had ensured the CQC rating for The Weir was displayed conspicuously in a place which was accessible for people and visitors to the home. Providers are required by law to display this rating visibly at 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 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 Prescribed creams were not always stored or administered safely. Where creams had been opened, their opening dates had not been recorded, which meant it was not always possible to be certain the creams were within their shelf-life period. We found the creams in people's bedrooms did not always marry with the creams they had been prescribed. Medicine stock levels had not always been recorded accurately, which made it difficult to establish whether people had received their medicines safely, and as prescribed.