Bupa Care Homes Limited

Avon Court Care 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

Avon Court Nursing Home provides accommodation which includes nursing and personal care for up to 60 older people. At the time of our visit 50 people were using the service. The bedrooms are arranged over two floors. There are communal lounges with dining areas on both floors with a central kitchen and laundry.

This provider of this service changed registration to BUPA Care Homes Limited in January 2017. This was the first inspection under this registration and therefore this is the first rated inspection under the new registration.

The inspection took place on 21st February 2017 and was unannounced. We returned on 22nd February to complete the inspection.

There was a registered manager in post at the service. 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.

Where people had risks which had been identified, there was not always sufficient guidance available in people's care records to guide staff on how to mitigate these risks. For example, one person's care plan did not give guidance to staff on how to help control their pain and the ongoing assessment of this was not consistently completed. The care records of another person who had developed a grade four pressure ulcer had information which stated their skin integrity could be at risk yet no steps had been taken to help mitigate this.

There were few details in people's care records about their likes, dislikes, preferences, interests and hobbies. Although staff said they knew people well, there was insufficient information documented for staff to refer to.

People told us at times they had to wait a long time for staff to respond to their call bell. One person told us "Staff work very hard but they really need more of them. The waiting time for the call bell to be answered is okay but at other times they can be quite a wait."

Medicines were mostly managed safely. However, advice had not been sought from a pharmacist regarding adding medicines to foods when giving them covertly. This was not in line with the service's policy on medicines and put people at risk from receiving medicines that may have had their therapeutic effects altered from being administered in this way.

There was a wide and varied activities program run by two activities coordinators. People said they enjoyed these activities and people looked happy and comfortable during the group activities we observed. However, people who remained in their rooms and chose not participate in the group activities did not have

the same degree of attention. Some people told us they only saw staff when they came into their rooms to do specific tasks such as bringing drinks or meals to them. There was a lot of documentation for people who had participated in group activities, but very little for those who had not and therefore it was unclear what level of social interaction they had.

People told us they felt safe. Comments included "I feel much safer than I did when I lived at home by myself" and "Knowing that there is always someone here to help me when I need it makes me feel safe". Staff were able to tell us what the different types of abuse were and how to report safeguarding concerns.

Documentation was available detailing when accidents and incidents had occurred. Where people had sustained an injury, this had been noted and followed up until the person was stable.

Staff told us they were confident that the training they received gave them the necessary skills and knowledge to enable them to support people in line with their needs.

People said they liked the food. We saw alternatives were offered when people did not like what was on the menu for that day.

People spoke positively about the care they received from staff. One person told us "I need help with my bath and the carers here will all take their time and they never rush me as I'm quite slow these days. I'm sure they must have lots of other jobs that they need to be doing, but they never let that show".

People, their relatives, friends and staff all spoke positively about the management team. They told us there was an open door policy where staff were able to approach the manager with any issues or concerns.

We found a breach of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not fully safe.

People told us they sometimes had to wait a long time for assistance. One person told us "Staff work very hard but they really need more of them. The waiting time for the call bell to be answered is okay but at other times there can be quite a wait".

Medicines were mostly managed safely. However, medicines for covert administration was not done in accordance with the service's policy on medicines management.

People told us they felt safe. Staff were knowledgeable in recognising signs of potential abuse and what to do if there were safeguarding concerns.

Is the service effective?

Good

The service was effective.

People said they liked the food and there was varied menu on offer. People also had access to specialist diets when required.

People were supported by staff who had the knowledge and skills to carry out their roles.

People had access to healthcare services and received on-going healthcare support.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about staff and the support they received.

People told us they were treated with dignity and respect. Comments included "I feel safe and well looked after and the staff respect my privacy.

People were offered choices and staff sought permission from people prior to carrying out specific tasks.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always give clear guidance for staff on how to support people in line with their needs and identified risks.

There was a wide and varied activities program although people who chose to remain in their room or were cared for in bed were not offered the same degree of support.

People and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously.

Is the service well-led?

Good

The service was well led.

Staff said the management team were approachable and felt they could raise concerns and seek guidance.

People and their relatives said they were regularly encouraged to provide their opinions and the service provided feedback and actions to these.

Systems were in place to monitor the quality and safety of the service provided. Where actions to improve the service had been identified, these were acted upon.

Avon Court 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 checked 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 21 and 22 February and was unannounced.

One inspector and two experts by experience carried out this inspection. Experts by experience are people who have had personal experience of care, either because they use or have used services themselves or because they care or have cared for someone using this type of service.
The areas of expertise for the expert by experience during this inspection was care homes, care of older people and dementia care.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

We also reviewed the 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.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with ten people who use the service and seven visiting relatives about their views on the quality of care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included ten care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents.

We looked around the premises and observed care practices.

We spoke with the registered manager, deputy manager, operations director and 10 staff including care staff, registered nurses, activities coordinators, housekeeper and chef.

Requires Improvement

Is the service safe?

Our findings

Some people told us they had to wait a long time for staff to respond to their call bell. Comments from people included "Sometimes it can take a while when they are busy in the mornings and early evenings, but I've never been desperate for the toilet by the time they got to me" and "Staff work very hard but they really need more of them. The waiting time for the call bell to be answered is okay but at other times there can be quite a wait". Another person was more positive about the time they waited; "There is a buzzer next to my bed. I don't think I've ever had to wait too long. Someone will always answer it".

We looked at a random selection of call bell times. From a sample period of 24 hours in February 2017, this showed the majority of people's call bells were being answered promptly; usually within two to three minutes. There were five occasions where the time to respond had taken over 20 minutes, with one of these taking 31 minutes to respond, with three of these occurring within one hour in the early evening. However, when emergency call bells had been activated, records showed these were responded to within an average of one minute.

Medicines were mostly managed safely. People who were given their medicines covertly (without their knowledge, mixed with food and/or drink) had assessments undertaken in line with current legislation, to determine this was in their best interests. Records showed best interest meetings had taken place involving their relatives and GP. When we looked at the medicine administration records for three people it stated their medicines could be added to hot drinks or foods in order to enable covert administration. However, confirmation on the safety in giving these medicines in this way had not been sought from a pharmacist. This was not in line with the service's policy on medicines and put people at risk from receiving medicines that may have had their therapeutic effects altered from being administered in this way.

We saw a medicines administration record (MAR) had been fully completed. This gave details of the medicines people had been supported to take, records of medicines people had refused and the reasons for this. There was a record of all medicines received into the home and disposed of. Where people were prescribed 'as required' medicines, there were protocols in place detailing when they should be administered. People told us staff provided good support with their medicines, bringing them what they needed at the right time.

During the inspection we observed part of a medicines administration round. Medicines trolleys were kept secure and locked when not attended. The staff member explained to people what they were taking and signed for medicines only when they were sure they had been taken. One person told us "I always get my medication on time" and told us medical equipment that needed re-ordering periodically for them was always in stock.

People told us they felt safe. Comments included "I feel much safer than I did when I lived at home by myself", "Knowing that there is always someone here to help me when I need it makes me feel safe" and "I'd speak to X (registered manager) if I had any worries or problems. She is always around if you need her".

Staff were able to tell us how to recognise signs of potential abuse and what action to take if they had any concerns. The registered manager told us safeguarding of vulnerable adults was regularly discussed during staff meetings. Where accidents and incidents had occurred, these were documented and followed up as required.

All areas of the home were clean and people told us this was how it was usually kept. The laundry room was clean and well organised, with clean and dirty items separated to prevent cross contamination. The chef showed us cleaning records for the kitchen area. Food storage temperatures had been recorded daily, food was labelled with dates of opening and the kitchen area was clean and tidy. Hand washing and drying facilities were available throughout the home and sinks were clean. There was a supply of protective equipment in the home, such as gloves and aprons, and staff were seen to be using them.

Good

Is the service effective?

Our findings

We looked at how the provider was meeting the requirement of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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).

Staff we spoke with demonstrated a good awareness of supporting people around the principles of the MCA 2005. One staff member told us it was about giving people choices to make their own decisions and when they don't have capacity to make a specific decision; these should be made in their best interests. Applications to authorise restrictions for some people had been made by the service and were being processed by their local authority. Mental capacity assessments had been completed and where people had been assessed as not having capacity, details of best interest decisions had been documented. When we spoke with two people and asked whether they felt restricted they told us "There are no restrictions at all. People can visit whenever they like and I go out with my friends and family often" and "I've never been told that I can't go anywhere I'd like, with whom I'd like".

The registered manager kept a log of when staff training, supervisions and appraisal were due. All staff had received mandatory training which included safeguarding, the mental capacity act, infection control, manual handling and health and safety. A matrix to indicate when staff training was due showed that safeguarding and infection control refresher training was overdue for most staff. The registered manager told us they had escalated this to the area training coordinator prior to the inspection and we saw documentation to support this. The registered manager told us they were confident staff were aware of safeguarding and infection control requirements as safeguarding of vulnerable adults and how to report concerns was regularly discussed with staff during staff meetings. The head of housekeeping had an ongoing competency assessment program for all staff to ensure they were meeting the requirements for the control and prevention of infections. This included a regular assessment of handwashing techniques and the use of personal protective equipment (PPEs).

Staff told us they were confident that the training they received gave them the necessary skills and knowledge to enable them to support people in line with their needs. Registered nurses working at the service told us they had support to maintain their professional registration and they received training in line with this. New staff received a comprehensive induction which included shadowing more experienced members of staff before working independently. Staff told us they received regular supervisions and an appraisal where they were able to discuss personal development plans. The registered manager told us during staff supervisions they reinforced the values of the organisation, encouraged staff to raise any concerns and worked with them to find solutions.

People told us they had confidence in the staff and told us they were able to provide the care they needed. Comments from people included "I think all of them (staff) are well trained. I've never had any problems with the carers as they've always been able to do everything I've needed them to do" and "I've had no problems with the carers. They've always been able to cope with my needs".

Details of food allergies and dietary requirements were available to kitchen staff. Staff asked people what they would for their meals from a daily menu with alternatives available if required.

People said they liked the food. Comments from people included "The chef here is really good. Everything is home cooked and fresh. There's nothing I don't really like, but if I don't fancy something, I can request something else anyway", "I prefer sweet things to savoury and the staff are being good at helping me with this" and I have to have a soft diet, but there is still so much choice, I never go hungry". We saw alternatives were offered when people did not like what was on the menu for that day. For example, we saw one person being given an alternative meal when a staff member spotted they had not eaten the one they had been given. The staff member asked them whether they would like an alternative and they were given what they asked for.

People had access to health services and a GP performed twice weekly visits to the home with additional visits according to any changing healthcare requirements. One person told us "I go and visit the dentist when I need to. It's all organised for me".

Good

Is the service caring?

Our findings

Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided, for example how they liked staff to support them with their personal care needs. Staff knew people well and were able to describe to us what they liked. One person's relative told us "Because all the staff are permanent employees, they all know X (family member) really well and understand his needs".

People told us they felt comfortable telling staff how they liked to be cared for. Comments included "The carers all know how I like things to be done so I don't need to tell them anymore. They do always ask me if I'm ready to get up and if I'm not, they will come back later" and They are all very polite and will always ask if I'm ready to do things. I never feel guilty saying no, can you wait?".

Staff were able to tell us about the importance of respecting people's rights to privacy and dignity. They told us how they ensured people's dignity was maintained for example, covering them as necessary to prevent them being exposed during personal care and whilst being hoisted. One person's relative told us "All the residents are treated the same whether they have visitors or not. They are all treated with dignity and kindness and their privacy is respected".

People told us they were treated with dignity and respect. Comments included "I feel safe and well looked after and the staff respect my privacy. Staff treat me with dignity and respect and I have a good rapport with them" and "I've never known anyone not knock, even when my door's already open".

The registered manager told us staff were committed and passionate in their work and often went above and beyond their role to support people. They told us staff were always keen to contribute new ideas and suggestions to continue to help improve the quality of care for people at the home. They gave us an example of when staff had come into work in their spare time to take people to see the Olympic torch arrive in town and that staff had helped to create a new garden area with a new bench and installation of bird feeders which had been donated to the home.

People spoke positively about staff, saying they were friendly and kind. Comments included "Staff are very good and cheerful and interested in you as a person" and "I need help with my bath and the carers here will all take their time and they never rush me as I'm quite slow these days. I'm sure they must have lots of other jobs that they need to be doing, but they never let that show". Comments from people's relatives included "Staff are so good at going above and beyond regularly with residents, you almost take it for granted. The activities coordinators make everyone feel part of the family" and "Nothing is too much trouble for the staff and there are lots of nice touches around, such as the plants in the home".

People were supported to be independent by staff who offered them support to make their own choices. Comments from people included "I have as much choice as I'd like. Nobody forces me to do anything I don't want to" and "I get up and go to bed at different times. The choice is very much mine". Staff told us they used different communication tools such as pictures and objects to help people who were unable to

articulate what they wanted to choose what they would like.

We saw a file where compliments had been received. On average, the service had received two written compliments per month. Comments from one sample of these received in the last 12 months included "Thank you all for the wonderful way in which you looked after me during my convalescence. I could not have wished for better attention".

Requires Improvement

Is the service responsive?

Our findings

Where risks had been identified, there was not always sufficient guidance available to guide staff on how to mitigate these risks. For example, in one person's care plan it showed they had been assessed as being at high risk of pressure ulcers. A hospital letter had stated physical difficulties this person had with moving certain areas of their body and had suggested staff sought advice from an occupational therapist if this caused a problem. This advice was not sought and there was no plan in place to ensure this person was given the necessary care to help prevent a pressure ulcer developing. When staff identified a pressure ulcer had developed and this was assessed by a tissue viability nurse, the wound was classified as 'grade 4'. This is when there has been full thickness of tissue loss. This may have been prevented if this had been regularly monitored and the necessary care delivered in response to this.

Another person who was at risk of experiencing pain had been prescribed pain relief for an open wound. When we asked a registered nurse how this person's pain was being assessed, they told us this was not possible as they were unable to communicate this with staff. When we asked another staff member whether this person experienced pain whilst being repositioned they replied "I think X is in pain all the time". When we looked at the medicines administration file for this person, it showed they had a pain assessment tool which had been completed by other staff. When the nurse saw this, they told us they hadn't realised this was in place.

This tool was called the Abbey Pain Scale and is used to assess pain in patients who are unable to clearly articulate their needs. This pain scale had not been completed every day, and the last time it had been completed, this person's pain level had been assessed as being 'moderate'. Although some pain relief had been given on the day of this assessment, there had been no review to assess the benefit of this medication and no re-evaluation of their pain following this. There was also no guidance available on which out of two different prescribed pain relief medicines would be the most appropriate. On the days this person had been assessed as having moderate pain, they had received the same amount or less pain relief as they did when they had been assessed as experiencing 'mild' pain. In addition, although pain relief was given on the days they had moderate pain, on at least three occasions no further pain relief was offered for up to two or three days afterwards.

In the care plan of the same person, there was no information to guide staff on other methods they may try help alleviate their pain. It stated in their care plan they could be 'aggressive' and 'agitated' and 'reluctant to cooperate due to pain and anxiety'. However, the only information available to guide staff on how to support them was to 'monitor their needs and well-being'. There was no information available on their likes and preferences to inform staff how they may provide comfort to them for example, music, sounds or items to hold.

When we looked at care plans of other people using the service, these also did not provide detailed information on people's likes, dislikes or preferences. For example, whilst people's care plans had details on food allergies, people's dietary preferences were not always documented. Staff we spoke with were able to tell us about the preferences of some people, this information was not available for those staff who were

new or for agency staff. This meant for people whose health had deteriorated and who had previously been able to tell staff what their preferences were, there was a risk that staff would be unable to support them by giving them foods they liked and in turn, may encourage them to eat more. For example, in the care plan of one person, it stated they required food that was chopped into small pieces but the only information on their preferences was that they liked a cup of tea without sugar. There was no information on what particular food and drink they liked to eat. This was a missed opportunity to gain information from this person whose ability to communicate had recently deteriorated and was experiencing difficulty expressing what they wanted.

Care plans did not always give clear guidance for staff on how to support people in line with their needs. In one person's care plan, it stated they had been assessed as having mild depression. The only guidance on how to support this person was to state they liked to be alone when they were feeling 'low' and that their 'mood' could be controlled by medication. There was also limited guidance on how to monitor this with the only guidance available in this person's care plan being 'X to receive support at all times, to monitor signs of increasing depression'. There was no information on how signs of increasing depression may present or what staff could do to support this person.

These shortfalls were a breach of Regulation 9(1)(2)(3)(a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 because each person did not receive appropriate person-centred care and treatment that was based on an assessment of their needs and preferences.

The provider valued feedback from people and their relatives and responded to their suggestions. Residents and relatives meetings were held throughout the year. Following feedback from people a list of actions was drawn up and compiled in a poster which was on display in the home. This showed what had been asked for and the progress following these requests. For example, some people had said they would like to go to a pantomime and there were details on display that they had done this. Comments from people and their relatives included "We have resident's and relative's meetings three or four times a year. They have sandwiches and cakes and we talk about what's happening here; future events and outings and any changes being planned" and "I come along to the resident's and relative's meetings which are very informative. If you suggest something, X (registered manager) will always thank you, take the idea away and will always let you know if it can be done and if not, why not".

The registered manager had a file of compliments and complaints they had received prior to our inspection. There was a procedure in place which outlined how the provider would respond to complaints. This was given to people when they moved in and was also displayed in the home.
There were only a few complaints received in the last 12 months. These had been thoroughly investigated and a response provided to the complainant in line with the service's complaints procedure. People told us they felt they would be comfortable raising a complaint if they needed to. Comments included "I've never had to make a complaint but I would be happy to raise a concern with staff as I know they would listen and are open about things" and "I'm very comfortable with the staff as I know them all well. I would talk to them about anything".

There was a wide and varied activities program run by two activities coordinators. People said they enjoyed these activities and there was laughter and happy faces during the group activities we observed during the inspection. One person's relative told us about some of the activities and trips their family member had done including a trip to the local wildlife park, the pantomime and the seaside.

We observed a quiz in one of the lounges. One person who had difficulty pronouncing words took part. They responded well to the quiz because they were able to shout out the one word answers and also enjoyed

singing the answers to a music quiz. There was friendly banter, smiling faces and a lot of laughter. People looked happy and said they liked taking part in this activity. We spoke to an activities coordinator who told us an activity was planned every day of the week. We observed people playing pool and taking part in other organised activities throughout the inspection. There were books, puzzles and games available in each of the lounges for people to help themselves to. When we asked people about the activities on offer they told us "We do a lot of singing and I like painting or doing some craft", "In the summer we can get out into the garden. I love gardening and it is really colourful here in the summer" and "We do Zumba to music which is always fun as you can do it standing up or sitting down".

Whilst there was an activities program which people told us they enjoyed, there was limited opportunity for people who chose to remain in their room or were nursed in bed to take part in meaningful activities of their choice and ability. These people were not offered the same degree of contact as those who spent most of their time in the communal areas of the home. In the daily notes and documents which detailed what daily social interaction people had, there was a lot of documentation for people who had participated in group activities, but very little for those who had not. When we asked staff where information was written about the interactions staff had with a person who was nursed in bed they told us this should be in their daily notes. However, there was no information in this person's daily records to support this. For another person who had participated in group activities, these activities and social interactions had been documented in their daily records and the majority of the days throughout the month had entries made regarding this. One staff member told us most social interaction with people who spent most or all of their time in their rooms took part during task orientated contact such as personal care.

One person who was in their room told us "The only time I see staff is when they bring me a cup of tea". Comments from two other people included "They (staff) just bring me a drink but there is never much time for anything else. No time to stop and chat, just onto the next person" and The staff never have time for a chat but I am treated well and they are there to help me when I need it".

One staff member told us when they had five staff on duty they had time to go and chat with people who were in their rooms however, when there were only four staff on duty, for example, due to staff sickness, this was not possible.

Good

Is the service well-led?

Our findings

People, their relatives, friends and staff all spoke positively about the management team. They told us there was an open door policy where staff were able to approach the manager with any issues or concerns. Comments from people included "X (registered manager) is lovely and she wanders around the home all the time" and "You can approach X (registered manager) anytime". A staff member told us "We all get on really well as a team. X (registered manager) is very supportive. If there are any problems I can approach her and she is usually able to solve any problems".

The service had a home improvement plan which had been in place over the last six years. During that time there had been changes made to a number of the living areas in the home. One of these had been to create a private lounge area where people could sit with their families. There was also a spa room and sensory area. In consideration of feedback received from people using the service, a pool table was obtained for one of the communal areas.

The service had systems in place to monitor the quality of the service being delivered. The registered manager completed a daily overview of the service, called a 'clinical walk around' in which they would walk around the service and speak with people and staff. They told us this enabled them to have an overall view of how the service was operating and enabled them to get to know people and staff really well. This also helped with the early identification of any potential issues such as deterioration in people's health or well-being. One person told us "I can't actually remember the manager's name, but she walks up and down and will usually stop for a chat, so I'd speak to her about any problems I had."

In response to our feedback during the inspection regarding the monitoring and management of pain relief for a person using the service, the registered manager responded immediately by creating an action plan to rectify this. This included scheduling supervisions for the registered nurses regarding the use of the abbey pain scale. They also updated the abbey pain assessment plan for this person and ensured this was placed within their medicine administration and care records. An updated guidance document was also written and distributed to staff.

Audits were carried out periodically throughout the year by the registered manager, deputy manager and external auditors. These audits included the management of medicines, equipment, accidents and incidents and care planning. Where issues had been highlighted, actions had been put in place to address these. Following our feedback during the inspection, where shortfalls had been identified in people's care records, plans were made to adapt the quality audit process to ensure these areas were reviewed in future audits.

Audits had been completed where call bell response times had highlighted delays in responding to call bells. The last audit had been completed in January 2017. When we spoke to the registered manager, they told us when delays have been identified they investigated by asking staff on duty and also the people who had called for assistance to identify the reason for this happening in order to address this. The registered manager also told us there had recently been some issues with staffing which had also been raised by people using the service. In response to this they had recruited more staff and were also in the process of

advertising for more.

A trends analysis was in place for incidents and accidents such as when people had a fall. This included collection of information such as what time of day, the locations and number of falls that were occurring to help staff identify key risks and areas where measures could be put in place to help mitigate further falls.

The maintenance of the home was managed well and included regular servicing and property safety checks to ensure people were safe. This included regular fire alarm testing and gas, electric and water inspections. Servicing of equipment was also completed and recorded to ensure it was fit for purpose. The service also had appropriate arrangements in place for managing emergencies including contingency plans in the event of a fire or loss of utilities.

The registered manager told us they networked with external services and organisations to keep up to date and share best practice. The service had close links with the local hospice who offered training for staff on end of life care. They also attended monthly care home meetings with managers from other BUPA homes to share ideas and look at ways to continually improve the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Each person did not receive appropriate person-centred care and treatment that was based on an assessment of their needs and preferences.