Care Quality Commission

Acegold Limited

Carlton Mansions Care Home

Inspection report

8 Apsley Road
Clifton
Bristol
BS8 2SP
Tel: 0117 973 4394
Website: www.brighterkind.com/carltonmansions

Date of inspection visit: 9 November 2015
Date of publication: 24/12/2015

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

Overall summary

This inspection took place on 9 November 2015 and was unannounced. The last full inspection took place in March 2015 and, at that time, three breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to safe care and treatment, staffing and person-centred care. These breaches were followed up as part of our inspection.

Carlton Mansions is registered to provide accommodation and personal care for up to 26 people. At the time of our inspection there were 23 people living in the home.

A registered manager was in post at the time of 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.

In March 2015 we found that staffing levels were not sufficient to meet people's needs. Some people did not receive personalised care and some people were left for

Summary of findings

long periods of time without staff interactions. The manager told us that staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. We viewed the staffing level rota over a five-week period from 21/9/15 – 25/10/15. During the day staffing levels were maintained in accordance with the dependency needs of the people who lived at the service. The night time staffing level fell below the level recommended by the CHESS tool on a number of occasions. The provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. The registered manager provided evidence of their current recruitment drive to appoint night time carers.

At our last inspection in March 2015 we found that the people's care plans were not sufficiently detailed to help staff provide personalised care based on current needs The provider sent us an action plan telling us what they were going to do to become compliant. During the inspection we found some improvements had been made but there were still areas which required further development. Care plans were well written and easy to navigate. They had all been reviewed and audited on a monthly basis. However, they were not consistently person centred. Life stories were not always completed which meant that staff did not always have an understanding of people's lives before they moved to the service.

The service did not have an activities coordinator in post. By not ensuring that a dedicated activities coordinator was available throughout the day the service did not enable people to carry out activities which encouraged them to maintain hobbies and interests.

In March 2015 we found that infection control guidance was not followed and the home was not suitably clean in all areas. We found that sufficient improvements had been made.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We saw information in people's support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been applied for appropriately. These safeguards aim to protect people living in homes from being inappropriately deprived of their liberty.

A range of checks had been carried out on staff to determine their suitability for the work. Staff were supported through an adequate training and supervision programme. Staff we spoke with demonstrated a good understanding of how to recognise and report suspected abuse.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

People and relatives spoke positively about the staff and told us they were caring. One person told us; "There is a warm friendly atmosphere. Staff will sit and talk things through. They are very supportive. We have a laugh together and that's really important." Staff told us they aimed to provide personal, individual care to people.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The overall feedback about the service and the manager had been positive. Staff spoke positively about the manager. People were encouraged to provide feedback on their experience of the service and monitor the quality of service provided. One relative commented; "I meet the manager regularly. She visited Mum in hospital when she was poorly. I am confident she is a good manager."

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Night time staffing levels were not sufficient to support people

Safe recruitment processes were in place that safeguarded people living in the home. A range of checks had been carried out on staff to determine their suitability for the work.

Requires improvement

Is the service effective?
The service was effective.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People's nutrition and hydration needs were met.

People had their physical and mental health needs monitored and had access to healthcare professionals according to their specific needs.

Good

Is the service caring?
The service was caring.

People and relatives spoke positively about the staff and told us they were caring.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Good

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

Care plans were not consistently person centred.

A complaints procedure was in place and the manager responded to people's complaints in line with the organisation's policy.

Requires improvement

Is the service well-led?
The service was well-led.

Systems were being operated effectively to assess and monitor the quality and safety of the service provided.

Where risks were identified, the provider introduced measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale.

Good

Summary of findings

People were encouraged to provide feedback on their experience of the service.	

Carlton Mansions Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 November 2015 and was unannounced. The inspection was undertaken by three inspectors 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.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas. 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 to us.

We spoke with seven people that used the service, three relatives and seven members of staff. We also spoke with the deputy and registered manager. We also spoke with two health professionals who were visiting the service.

We reviewed the care plans and associated records of five people who used the service. We also reviewed the medicines administration records (MAR's) of the people who lived at the home. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we found that that people were not always safe, as there were not always sufficient numbers staff to support their needs. The provider sent us an action plan telling us what they were going to do to become compliant. We found that insufficient improvements had been made.

The registered manager told us that staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. We viewed the staffing level rota over a five-week period from 21/9/15 – 25/10/15. During the day staffing levels were maintained in accordance with the dependency needs of the people who lived at the service. We did not observe unsafe practice and people received the appropriate support at the correct times such as meal times, medicine rounds and when personal care was needed. One person told us; "When I need them staff come pretty quickly. There are some bottlenecks. First thing in the morning and over lunchtime, but it's not too bad." One member of staff told us; "staffing has improved since March (previous inspection date). I know there's an on-going recruitment drive."

The service was experiencing difficulties with maintaining night time staffing levels. The night time staffing level fell below the level recommended by the CHESS tool on a number of occasions. The CHESS tool recommended that 2.5 people should cover the night time shift. On fifteen occasions it fell below three people and there were two people providing cover. On one night there was only one member of staff providing night time cover. This meant that the provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. The registered manager provided evidence of their current recruitment drive to appoint night time carers.

There continues to be a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in March 2015 we found that best practice had not been followed in relation to infection control and the home was not suitably clean. The provider sent us an action plan telling us what they were going to do to become compliant.

During this inspection we found that sufficient improvements had been made. Since our previous inspection the provider deep cleaned the kitchen. In August 2015 the kitchen had been awarded a five star food hygiene rating by the local authority. Daily and monthly cleaning schedules were completed and food was stored at the correct temperature. We did advise the registered manager that the flooring had holes in it and the tiles and skirting boards would benefit from a further deep clean. We noted that the monthly food safety audits conducted in the previous two months had also raised concerns regarding the flooring. The registered manager agreed to assess the position.

Staff knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons were readily available and we observed staff using it prior to assisting people with personal care. Staff also wore aprons when assisting people to eat. Wearing PPE reduces the risk of cross infection. Hand gel dispensers were available throughout the home and were full and in working order.

We observed that the hallways, rooms, communal areas and shared facilities were clean but that some of the carpets were worn and tired looking. Baths, sinks and sanitary equipment was clean and functional. Each room had a scheduled daily clean and a monthly deep clean. The housekeeper was using different colour coded cloths, mops and buckets to minimise the risk of cross- infection in the home. The service on the whole was clean and tidy and free of odours. One person commented; "I like my room. It is nice and clean and kept very tidy."

Medicines were generally managed appropriately so that people received them safely. People received their medicines on time and as prescribed. We observed part of a medicines round and the person responsible for administering medicines demonstrated they were knowledgeable about the medicines they were giving to people and the reasons why they had been prescribed. They checked people had swallowed tablets before signing the medicines administration record (MAR) charts.

MAR charts had been signed by staff to indicate medicines had been administered as prescribed. There were no gaps in the MAR charts we looked at. Topical MAR charts were also signed and up to date to indicate that creams and lotions had been applied by care staff as prescribed.

MAR charts contained photographs of the people using the service which had been dated. People's allergies were

Is the service safe?

noted to alert staff. However, people's preferences in relation to how they preferred to take their medication were not documented on the front of MAR charts. Although the member of staff administering the medicines demonstrated they knew how people preferred to take their medicines, having this information in place would assist new staff members and would demonstrate a person centred approach to medicines administration.

Medicines were stored in a locked trolley. Controlled medicines which have legal requirements relating to storage and dispensing were stored correctly. However, the controlled medicines record book had gaps where a witness to the dispensing should have been signed. There were four missing signatures, two on 31/10/2015 and two on 07/11/2015. This was highlighted to the deputy manager during the inspection and we were informed this was a night staff error which would be addressed when they were next on duty. Apart from these missing signatures, the record book was fully completed.

Although the stock balance of the controlled medicines was checked regularly, when people left the service or controlled medicines were no longer required, the stock balance in the record book did not reflect this. This meant that when medicines were no longer required and were disposed of safely and in line with best practice, the record book was not updated to reflect this. For example, the stock balance showed medicines were still in stock even though they weren't. This was discussed with the deputy manager who informed us they would review this procedure with immediate effect.

Medicines that required storage in a fridge were stored correctly. The fridge temperature was monitored and the log was up to date. Nobody was self-administering their medicines or receiving them covertly. When one person had experienced difficulty swallowing tablets, the service had reviewed their medicines with the GP and changed the person's prescription to a liquid formulation.

People's medicines were reviewed monthly by the GP in conjunction with the deputy manager. This meant the GP was kept informed of the efficacy of people's medicines and that medicines were changed appropriately and when necessary.

The provider also undertook quality audits which incorporated an audit of the home's medication provision. This audit had highlighted that although 100% of staff had completed an eLearning module on the care of medication; only 67% had completed their Care of medication foundation eLearning module. We were informed that letters had been sent to the staff to remind them to complete the training and that the registered manager was monitoring this on a weekly basis.

Risk assessments in relation to keeping people safe were in place within care plans and had been reviewed monthly. People's moving and handling plans were clear and informative, with pictures to inform staff of the correct equipment to use. Staff said they had all received manual handling training, and the manual handling trainer explained the improvements they had implemented since our last inspection For example, in one plan, the instructions for staff were "Stand Aid. Stand Aid sling. The loop configuration to use is orange. There was a picture of the sling, including detail such as "Label to be facing outwards". The guidance included a note to staff informing them that if they were unsure or didn't feel confident, they should not carry out the procedure. Copies of the manual handling plans were in people's rooms so that staff could access them easily.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant's identity and their employment history.

Staff we spoke with demonstrated a good understanding of how to recognise and report abuse. All staff gave good examples of what they needed to report and how they would report concerns. Staff told us they felt confident to speak directly with the registered manager and that they would be taken seriously and listened to. They also advised that they would be prepared to take it further if concerns were unresolved and would report their concerns to external authorities, such as the Commission.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

Requires improvement

Is the service safe?

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The

manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up.

There were appropriate governance systems in place to monitor health and safety and the welfare of people. These included audits on fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors.

Good

Is the service effective?

Our findings

Staff were supported through an adequate training and supervision programme. Staff told us they had received supervisions recently. We reviewed staff records which demonstrated that recent staff supervisions had been conducted. This meant that staff received effective support on an on-going basis and development needs could be acted upon

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as health and safety, safeguarding, moving and handling, food hygiene and infection control. The remaining induction training period was over 12 weeks and included training specific to the new staff member's role and to the people they would be supporting. A training plan was in place which demonstrated that the necessary mandatory training had been completed by staff members. The home had a 98% compliance rate with its own mandatory E learning programme. Safeguarding, dementia and mental capacity act training had recently been completed by staff members.

Staff had the necessary skills and knowledge to support people using the service and accessed other healthcare professionals for advice and support when required. We spoke to one visiting health professional who said "The staff always ring for advice when they need it. I know the tissue viability nurse has been out to provide training, and just recently the continence advisor came here too". Care plans contained notes from reviews by other health professionals such as the GP, the hospice team and the dementia care team. However, it was not clear if all staff had read and understood the input from external healthcare teams. For example, in one plan, the dementia care team had noted that the person craved affection, and suggested that staff took the person for a walk and provided education and support for the next of kin. When we discussed the person's care with staff, they were not all aware of this information. This meant that despite people having access to healthcare services, the guidance provided was not always followed or understood by staff.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We viewed in people's support plans information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The current arrangements showed that the staff had been involving the necessary people such as relative's, representative's and health professionals and followed a procedure to ensure they had an appropriate agreement to restrict people's rights.

The staff we spoke with told us they had received training on the Mental Capacity Act. They understood that informed decision making and ability to consent was dependant on people's mental capacity. Plans we looked at contained mental capacity assessments for all aspects of people's care. One member of staff told us; "We always obtain verbal consent and try and establish preferences. We encourage people to make choices."

People's nutrition and hydration needs were met. People's nutritional assessments had been completed and reviewed. Where concerns had been noted, external guidance had been sought. For example, in one person's plan, staff had requested an assessment by the Speech and Language assessment team (SALT). This had taken place and the review notes from the SALT team were in the care plan. The person had been assessed as not at risk of choking, and the care plan informed staff they should cut the person's food up and encourage them to eat. We observed staff following the guidance during lunch. Where people had specific dietary needs, for example, due to a diagnosis of diabetes, there was clear guidance documented for staff on the type of foods the person could eat. We spoke with the chef who demonstrated a sound understanding of people's specific dietary requirements, allergies and required consistency of food. Owing to people's requirements being displayed on the whiteboard in the kitchen the information was accessible for all staff to view.

People spoke positively about the meals. Comments included; "They know if I don't like something them I am not going to eat it so they make sure that they get me

Good

Is the service effective?

something I like"; "I think that the food is very good here. I've no complaints at all"; and "I've not eaten here but I have seen Mum's meals and they look very good. She seems to enjoy them."

At the lunch time service people were offered choices of food and drink. We did observe that people living with dementia were not shown pre-prepared meals or pictorial indicators of the food choices to enable them to make an informed decision. We were told by a member of staff that there were plans to introduce this approach. The dining room was well set out and laid with the suitable cutlery. People who chose to eat in their room were supported appropriately. Staff checked regularly to see if people were alright or needed anything else. Snacks, fresh fruit and hot or cold drinks were provided at regular intervals during the day. People told us that if they wanted a snack or hot drink the staff will get them what they ask for. People had access to drinks in their bedrooms. There was also a drinks dispenser situated in the dining room, if people wanted to help themselves.

The layout of the communal areas in the service appeared restrictive. The majority of people were sat in the lounge by late morning, although some people had chosen to stay in their rooms. There was another lounge available for people to use. The television was on in this room, but nobody was watching it. There was limited space for people to move around independently; the communal hallway was not large and was a thoroughfare for staff to get to different parts of the building. Several people sat in the hallway, which meant the area was busy.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff and told us they were caring. People's comments included; "Wonderful care. The girls are very good and are looking after me very well. I have no worries they are lovely people"; "Very good care here. People treat me as a person"; and "I'm happy to come down in the morning and see the lovely people who look after us." One relative commented; "The care is good. There are more staff now to support people."

People were treated with kindness and compassion by staff. There were lots of positive interactions observed during the day; for example, we observed one member of staff spending time blow drying and styling one person's hair, although this was being done in the corridor upstairs rather than in their bedroom which would have been more private. Another person's hair had also been styled earlier that day and when we commented on this they said "Oh thank you, lots of people have said my hair looks nice today".

When one person began to pull their clothing up, a member of staff immediately intervened in a discreet way, and assisted them to the bathroom.

Visiting health professionals spoke positively about the care people received. They said "The staff are all very caring, they're great" and "The staff are lovely here, very polite and caring".

Several of the staff we spoke with had been employed at the service for several years and said "I really enjoy my job, I like making people happy" and "I love working here, I would recommend this place to anyone".

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people choice and encouraged independence such as enabling them to make choices of clothes and drinks. People were asked if they needed personal care. One person had their hands covered in chocolate and was asked if they wanted their hands wiped. The person said a clear "no" and the carer respected the person's decision. On another occasion one person was asked if they would like their meal in the dining room. They asked to have it in the lounge and the carer's respected their decision. One person told us; "They always ask me if I need any help they are very good at taking my wishes into consideration."

Requires improvement

Is the service responsive?

Our findings

At our last inspection in March 2015 we found that the people's care plans were not sufficiently detailed to help staff provide personalised care based on current needs The provider sent us an action plan telling us what they were going to do to become compliant.

During the inspection we found some improvements had been made. However, there were still areas which required further development. Care plans were well written and easy to navigate. They had all been reviewed and audited on a monthly basis. For example, we looked at one care plan which had been reviewed to reflect the person's changing needs following a fall. Where audits had identified actions, these had all been addressed within the specified timeline.

Where a person lacked the mental capacity to make specific decisions about their care and treatment, their best interests were established and acted upon in accordance with the Mental Capacity Act 2005. This included the duty to consult with others such as health professionals, carers, families, and/or advocates where appropriate. Relatives with power of attorney over their relative's care and welfare told us that they were consulted about their relative's on-going care needs and they were given regular up-dates. People who were able to make their own decisions told us that staff listened to them and gave them the support they needed.

We found that care plans were not consistently person centred. Life stories were not always completed which meant that staff did not always have an understanding of people's lives before they moved to the service. For example, in one person's plan, it stated they had been born abroad, but there was no record of where else they had lived. The person walked around the building a lot, and had gone into other people's rooms uninvited. When we asked staff why the person did this, they did not know. Although the staff knew of the person's previous occupation, they had not gained any more information in relation to this to see if this contributed to their behaviours. One member of staff said "I talk to [person's name] about their job, remind them they are here now". The care plan informed staff the person preferred to stay in their room, but when agitated they would go into other people's rooms. Staff had documented they were concerned the person was "looking for company" but there was nothing to indicate they had tried to gain more detail about the person as an individual and why they were looking for company.

We spoke to staff about another person using the service who had been reviewed by the dementia care team in relation to their behaviour. Staff were not aware of the underlying reasons for why they behaved how they did despite this being documented within the care plan. This meant that care was not always person centred because the staff did know enough about people's histories. Staff said; "We all have access to the care plans and can read them if we want to, or we can hear about changes at handover".

There was no activities co-ordinator in post, and this meant that people did not always have access to meaningful activities. We did not observe any meaningful activities during the day. A visiting health professional said "I do think the residents need more stimulation". We were told by the registered manager that the service is in the process of trying to recruit an activities coordinator. The current activities programme provided by the carers lacked mental and physical stimulus. One person told us; "I could do with more things to do." By not ensuring that a dedicated activities coordinator was available throughout the day the service did not enable people to carry out activities which encouraged them to maintain hobbies and interests.

The provider had not consistently ensured that people using the service receive person-centred care that met their needs and reflects their personal preferences. **There continues to be a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. One relative commented; "You get a welcome here and people have time for you."

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Where issues of concern were identified they were taken forward and actioned. No formal complaints had been received since our previous inspection. Some people we spoke with had raised

Requires improvement

Is the service responsive?

informal complaints with the manager and felt they were listened to. One relative told us; "I have complained and things have been dealt with. On one occasion [person's name] teeth went missing and they were found in amongst the bed clothes. I asked the carer's if they could remove his teeth at night and as far as I know they are doing it." Another relative told us; "[person's name] needs to be checked on every hour at night because he can wander. I noticed in the book that on a particular day of the week he was only being checked every 3 hours. I mentioned it and he is now checked at the correct intervals." Comments from people who lived at the service included; "I don't complain because I have nothing to complain about at all" and "the girls listen and I tell them if I have a problem. They do fix it if they can."

Good

Is the service well-led?

Our findings

Staff spoke positively about the registered manager and considered her to be approachable. One member of staff told us; "the manager gives us lots of support." The registered manager told us that her "door was always open."

The manager communicated with staff about the service to involve them in decisions and improvements that could be made; we found recent staff meeting minute's demonstrated evidence of good management and leadership of staff within the service. Agenda items identified action items which needed to be taken forward such as training. The minutes also covered the values of the service and encouraged staff to discuss issues they had.

The regional manager visited the home regularly and compiled a monthly visit report. The visits were used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. Clear action plans were evident and timescales given to areas in need of attention. Actions from previous monthly visits were reviewed to ensure appropriate actions had been forward within the required timescales. The registered manager stated she was well supported in her role by the regional manager and the managers of other homes in the company. The registered manager attended monthly managers meetings where good practice could be reflected on and the managers could share experiences in order to reflect and learn.

The registered manager had a number of internal systems used to monitor quality on a regular basis such as flash meetings held daily with heads of departments to communicate current concerns and action required. To ensure people's care needs were met the deputy manager conducted monthly audits on nutrition, admission, resident of the day, falls, safeguarding, medication, mental capacity and pressure ulcers. In addition to this residents who were particularly vulnerable due to their current needs were monitored by the management team and actions were recorded in relation to any concerns raised.

The home had introduced a 'resident of the day' system which focused on a particular person on a rotational basis. The family of the person receive an invite to attend the home to speak in person about their family member. The care plan was audited, their room had a deep clean and the resident had time to speak with key departmental heads such as the registered manager, the chef, housekeeping and maintenance to ensure the service is sufficiently meeting their needs. This demonstrated the way the service is reviewing care and adapting to change.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. Annual customer surveys were conducted with people and their relatives or representatives. The results of the survey were available in the foyer for all to access and how the service was responding to the issues raised. Relatives and relatives meetings also took place to gain people's views. Items discussed included activities and menus. Overall positive feedback was received about the leadership from people and their relatives. People told us that they knew who the registered manager was. She was available when needed and they felt they had a good relationship with her.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not consistently ensured that people using the service receive person-centred care that met their needs and reflected their personal preferences.