Kingsmead Care Home Limited

Kingsmead House Care Home

Inspection report

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Tel: 01252549339

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was an unannounced inspection that took place on 11 January 2016.

Kingsmead House Care Home is a nursing home for up to 40 people, with a range of support needs including personal care, nursing needs and for people who require end of life care. On the day of our inspection there were 26 people living at the home.

The home was run by a registered manager, who was present for part of the day of the inspection visit. '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 and associated regulations about how the service is run.

People were not always protected from harm and ill treatment. Not all staff had training in safe guarding people; therefore not all care staff were always able to keep people safe.

People were not always protected from potential risks. Some risks to people had been identified but there was no management plan in place. Risk assessments were not always reviewed for people when their needs changed.

People were not always supported at their end of life to have a comfortable and dignified death. Pain assessments were not always in place. People's wishes and views were not routinely obtained; this meant that the staff could not always care for people how they wanted.

People often had to wait to get their as required pain relief medicines. People's medicines were not always managed and administered safely. Medicines were stored and disposed of safely.

People did not always receive effective care. The registered manager had not always ensured that staff had the training, knowledge; skill and regular supervision to enable to them care for people safely and effectively. Some new care staff had not received induction training, which included mandatory training such as fire safety, mental capacity and safe guarding people.

Peoples care plans often missed out vital information as to how to care for people with specific health needs. Care plans were not personalised.

People's views were not routinely listened too. People, their relatives and health professionals told us they raised concerns and complaints to the registered manager and they had not been dealt with.

There were no robust systems in place to monitor, review and improve on the quality of care. The registered provider and registered manager lacked oversight of the quality of care being delivered.

Recruitment procedures were not always followed as the registered manager did not always ensure that staff were of good character as references were not always obtained prior to employment. The registered manager had ensured staff had DBS checks had been completed prior to starting employment at the home.

People's human rights could have been affected because the requirements of the Mental Capacity Act were not always followed. For people that lacked capacity to make decisions there was not always a mental capacity assessment completed and a best interest decision made.

The registered manager had recently increased the staffing levels in the home, as people and professionals had raised concerns there were not enough staffing. People told us that staffing levels were improved.

People's care would not be interrupted in the event of an emergency if people needed to be evacuated from the home as staff had guidance to follow. Staff knew how to respond to accidents and incidents.

People were supported to have sufficient food and drink. People told us the food was good and there was choice. People were supported to maintain their health by accessing external health professionals such as GP and community matrons.

Staff were caring. Staff had developed positive relationships with people and were kind and considerate. People's dignity and privacy was respected.

During the inspection we found 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Not all staff knew about how to keep people safe, what the signs were and who to report concerns to.

Risks to people were identified but not always managed safely.

People did not always receive pain relief medicines when they needed it. People's medicines were stored safely but not always administered safely.

There were no robust systems in place to check staffs character upon recruitment. DBS checks were completed.

Staffing levels had improved.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the right training and knowledge to care for people effectively.

People's human rights could be affected because some the requirements of the Mental Capacity Act were not always followed.

People had enough to eat and drink and said they had a good choice of food available to them.

People had access to health care professionals to maintain their health needs

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive safe and effective end of life care.

People were not always involved in making decisions about their care.

People told us that staff were caring and had positive relationships with them. .

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People, their relatives and health professionals said they did not feel listened to and their concerns were not always acted upon.

People were not always involved in or always receive personalised care.

Care plans did not contain sufficient detail and some people did not have care plans for identified needs.

There were some activities on offer for people however activities were not individualised to the needs of people.

Is the service well-led?

Inadequate

The service was not well led.

There were no robust quality assurance systems in place to review, evaluate and improve care.

The registered provider and registered manager did not have oversight of the day to day issues that had arisen.

Complaints were not always listened to, recorded and dealt with effectively.

Staff said they felt supported by the manager.

Kingsmead House 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.

The inspection took place on 11 January 2016. This was an unannounced inspection.

The inspection was brought forward due to information of concern that we received, this relates to low staffing levels and staff not having the right skills or knowledge to work with people with end of life needs.

The inspection team consisted of three inspectors and a specialist nursing advisor in end of life care.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance teams, two health care professionals, and care management. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as the inspection was brought forward due to concerns raised. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During and after the visit, we spoke with five people, three relatives, the registered manager, the head of care (deputy manager), the maintenance person, the chef, an administrator, an activities co-ordinator and five members of staff. After the inspection we spoke with one health care professional. We spent time observing care and support provided throughout the day of inspection, at lunch time and in the communal areas.

We looked at eight people's care records, medicine administration records, staff rotas and recruitment files and supervision and training records. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

This was the first inspection of the service since it was registered in April 2015.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from potential risks to their health or wellbeing. Not all people had risk assessments in place that required them. For example, one person was assessed as being at risk of social isolation, however there was no management plan put in place. A person whose health condition indicated they were at risk of weight loss had no risk assessment in place in relation to how this was managed. We found they were not weighed on a regular basis despite the care plan stating 'needs to maintain weight.' The same person had a care plan that stated 'risk of falls', however there was no falls risk assessment in place. As the risks to people had been identified, but there was no management plan in place, this put people at risk of harm.

Other risk assessments were not reviewed regularly, particularly when people's needs had changed. For example a person had a fall and now spent a lot of time in bed. A risk assessment to ensure the person's skin remained intact had not been updated despite the fall occurring three weeks previously. Another person, whose mobility needs had changed, required new equipment and supervision from staff when walking. They had not had their mobility risk assessment updated for three weeks. Without risk assessments the risks to people and staff would not be managed safely as staff may not know how to support people safely.

As risks to people were not always managed safely this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always safe from avoidable harm and abuse. People told us that they generally felt safe. One person said "I feel quite safe." Another person told us "At one time I felt safe, I don't not feel that way now." People were not always protected from the risk of improper treatment because staff were not always able to identify situations that constituted ill-treatment. Most staff had knowledge of safeguarding procedures and some staff knew who to contact if they had concerns however some new staff said they were not clear about safeguarding and who to report concerns to. Staff training records showed that six new staff members had not received training in safe guarding prior to working with people. The home had a safeguarding and whistle blowing policy with the contact details of the local safe guarding team. However there was no policy available on display in the home for people or visitors to know who to contact.

As some staff were unaware of how to keep people safe, this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recording and administration of oxygen to people who needed it was not always carried out appropriately. There were a small number of people who were prescribed oxygen; however there was only one prescription recorded on the Medicines Administration Record (MAR) chart. The nursing staff were not checking the person's oxygen levels and we found that they were receiving too much oxygen. We raised this with the nursing staff who responded to this and put the amount right.

Other medicines were managed, stored and disposed of safely. We found the medicines cabinet was organised and people's medicines were labelled. The nursing staff who were administering people's

medicines had a good understanding of what the medicine was for and what possible side effects may occur. MAR charts were completed accurately and each contained a photograph of the person to ensure the medicine was given to the right person.

People told us there were not always enough staff to meet their needs. One person told us "Sometimes there could be more staff, its better recently." Another said "There is not enough staff here to meet my needs." One relative said "One weekend I had to chase around the building to find care staff, it took me 20 minutes."
The registered manager told us that the staffing levels had recently increased in the home due to the concerns raised by health professionals. People told us that the staffing levels were getting better. On the day of inspection we were told there would be one nurse per floor and two carers with one carer who would 'float' between all the floors. We observed this number of staff on the day.

People did not always have their medicines on time. Some people told us they had to wait to get pain relief after pressing the call bell; one person said "I get my medication when I need it, another told us "Sometimes I have waited up to one hour before I get my pain relief medication." Nurses told us when people need to have a controlled drug administered, they had to find another nurse or the deputy manager (as two staff members are required to) and this took some time. The meant that some people had to wait for their pain relief medicine to be administered.

People told us that when they pressed the call bell, they often had to wait. One person said "I can wait 10-15 minutes before someone comes to help me use the toilet." Another said "I can wait 20 minutes for staff to come to help me use the toilet, so now I start to walk on my own." We did not see this happen on the day of inspection.

Appropriate checks had not always been carried out to help ensure only suitable staff were employed to work at the home. The provider had not always checked that staff were of good character, by ensuring that references had been provided.

We recommend that the registered manager completes the appropriate checks when recruiting staff in line with current guidance.

Other checks including the Disclosure and Barring Service (DBS) had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's care and support would not be interrupted or compromised in the event of an emergency, as the service had a contingency plan in place. Guidelines were in place for staff in the event of an unforeseen emergency. Each person had an individual personal emergency evacuation plan (PEEP); however they were generic and did not detail people's individual needs should they need to evacuate the building. All the necessary health and safety checks were carried out as required, such as fire equipment testing and checks to ensure care equipment was safe for use.

Care staff managed accidents and incidents appropriately and had completed accident and incident forms.

Requires Improvement

Is the service effective?

Our findings

Staff had not always received training and support to enable them to provide effective care to people. New staff had been recruited some of which had not worked in a care setting before. Staff told us they had not had training since they started working in the home. The training records reflected this. The registered manager said that they were waiting for all the new starters to arrive and then complete the training, which would ensure that all new starters had it.

Seven new staff members that have worked at the home since October 2015 onwards had not received the provider's mandatory training which is part of their induction. This included fire safety, health and safety, basic care skills and safeguarding people. The registered manager told us that staff were not undertaking the Care Certificate. This is a certificate that sets out standards and competencies for care workers. This meant that staff did not always have the skills and knowledge to provide safe and effective care to people.

No care staff or nurses have received training in end of life care, nutrition and hydration, infection control, risk assessments and medication awareness. Staff told us that they had not always received training and some new staff members said they did not know when they were getting training. Some staff had training in the Mental Capacity Act, however staff had limited knowledge of the practises as staff gave examples of people who lacked capacity which was contradicted by information in people's care plans which stated they had capacity to make all decisions.

Nursing staff were not always carrying out medical checks on people that needed their health monitored. One person who was diabetic should have had their blood sugar checked weekly. This had not been done for two weeks and on the last day, a high blood sugar was recorded and staff had not acted upon this. A few people needed their blood pressure checked regularly; this was recorded by nursing staff as being done on an adhoc basis. One person needed their blood pressure checked daily and this had not been done for 10 days. Another person needed their blood pressure checked twice daily as requested by the GP; this was only done once a day, with several days missing. The nursing staff could not give a reason as to why this had happened. However they followed it up and checked their blood pressure.

Staff did not receive sufficient support to fulfil their roles and responsibilities. Staff did not have regular, or often no supervision or appraisal. The registered manager confirmed that staff were not having regular supervision. The homes supervision policy states that formal supervision should occur 'at least once every month'. As staff supervision did not occur, there was a risk that people may not be effectively cared for as staff were not given the regular opportunity to have their skills and knowledge evaluated, develop skills through the exchange of information or review and discuss individual people's welfare issues.

The registered manager has not ensured that staff have the skills and knowledge to enable staff to provide effective care for people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's human rights could be affected because some the requirements of the Mental Capacity Act 2005

(MCA) were not always followed. The MCAMCA 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.

For people who had capacity to make decisions regarding their care they had mostly signed to agree to receive their care. One person lacked capacity to make decisions regarding some aspects of their care. The notes recorded that this person lacked capacity to make a decision regarding whether they had bed rails up on their bed. A mental capacity assessment had not been completed, nor had a best interest meeting occurred. As a result this intervention may not be in the person's best interests.

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). The registered manager told us that no applications had been made for DoLS. However if restrictive equipment is used such as bed rails for people who lack capacity and it is in their best interests, a DoLS application should be made to the local authority. The registered manager has not ensured this has occurred.

We recommend that the registered manager considers whether DoLS applications need to be made for people in line with current guidance.

People told us they had enough to eat and drink and that the food was generally "good". One person said "If there is not something that I like I can always have an alternative." Another said "Yes the food is nice, I choose the day before and if I don't like something they will make me something else."

We observed a lunch time. People choose their food the day before on a menu card. People had a choice of where they would like to eat, either in their rooms or in the dining room. For those people who choose to eat in their bedrooms, staff brought their food covered out to them on a tray.

The meal time was pleasant with calm music playing in the background. Staff offered people a choice of drinks, including wine. People in the dining room were given a choice of vegetables and deserts. People took their time to eat their meals.

The chef told us that the kitchen staff knew about people's likes, dislikes and any allergies people may have. The chef said that the care staff told the kitchen staff of people's dietary changes such as people needing a soft food diet. The chef said that they would often visit people and talk to them about trying out different meals, getting feedback on the day's meal.

People had a jug of cold drink in their bedroom for them to help themselves. Hot drinks were available at times throughout the day. People's weights were monitored on a monthly basis.

People were supported to maintain their health by having access to external health care support. We spoke with a Community Matron and Specialist nurses from the local hospice who told us they provided a lot of support to the nursing team and to people who were receiving end of life care.

We saw evidence in people's care plans that the GP visited people when required, and that people were able to access other healthcare professionals such as psychiatrists, opticians and podiatrists.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring. One person told us "Staff care a lot." Another said "By and large staff are caring and kind." Another person said "Staff are very caring; always ask if everything is ok."

Relatives told us on the whole that the care provided to their relatives was good and staff were caring. Some relatives told us that sometimes due to the high use of agency staff; staff could not always develop relationships with people. However one relative said "Staff are wonderful, they know my X well." Another said "X is happy here, cared for and well looked after."

Despite these comments we found that people were not always supported at their end of life to have a comfortable and pain free death. People's wishes, spiritual needs and preferences were not always recorded in their care plan. As staff were not always aware of people's wishes upon end of life, this meant that staff could not always provide the care that people wanted.

We spoke with one person who was receiving end of life care. They told us that they were scared and lonely. Staff were not aware of how this person was feeling and there was no information recorded about how staff should support the person. This meant that the person was not having their end of life needs met.

There were not always pain assessments in place for people who were at end of life. Pain assessments give guidance to staff about people's pain levels, the impact it has on people's well-being and at what point they would like to have pain relief medicine. One person told us they were experiencing more pain, they had not had their pain assessment reviewed for three weeks. This meant that people were not always able to receive pain relief medicine when they needed it as staff did not have the information on how to recognise when a person was in pain.

People did not always have their end of life care needs met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were inconsistencies in how people were involved in their care plans. Some people told us that they were not always involved in making decisions about their care. One person told us that their relative had had a fall recently; we asked if they had a falls care plan completed and if they had been involved in it, the relative and the person said they had not. This was confirmed by reviewing the persons care records. Two other people told us that they had not been involved in their care plans. This means that people's preferences and wishes may not be clear to staff caring for them.

However, other people told us that they had "One person said "Staff look after me the way I want, I can have a bath when I want." Another told us "I can have a shower when I want and the staff wash me the way I want." One relative said "I was involved in developing my relatives care plan and I signed it."

We recommend that the service reviews how it involves people in their care planning in line with current guidance.

People told us that the registered manager came to visit them in their home prior to moving in and found this helpful and made them feel at ease about moving in. We saw that people had bought in some of their own furniture and personal belongings to make their bedrooms feel homely.

Staff had developed positive relationships with people. We observed staff interaction with people, asking them how they were, chatting to them about their plans for the day. Staff spoke with people in a kind and caring manner.

We saw that people looked relaxed and comfortable with the care provided and the support received from staff. We observed two staff members supporting a person to move by using a hoist. Staff spoke to the person about family members recent holidays, the staff member told the person what was happening and regularly asked if the person "are you comfortable?" whilst being hoisted.

People were well dressed and their appearance was maintained by staff. For example, with appropriate clothes that fitted and nicely combed and styled hair which demonstrated staff had taken time to assist people with their personal care needs. We observed one staff member with a person who had just finished supporting them with their personal care and asked "Is there anything else I can do for you? Get for you? "

People's privacy and dignity was respected, for example, we saw staff give people privacy when they wanted it. One staff member told us they were always conscious of people's privacy. They said they would always knock on people's doors and ensure doors and curtains were closed during personal care. We saw people knocking on doors and waiting to enter until being told it was ok. We saw staff addressed people in a manner they wished to be addressed.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised and responsive care. Peoples care plans did not record people's views and preferences for care. We found that people's pre-admission assessments often were incomplete and detailed information was not available. Information regarding people's interests, preferences of what time people would like to get up and how they liked to spend their day were incomplete. Some had basic details missing, such as age, previous occupation, partner details. With this level of information missing, staff were not always able to provide responsive and effective care.

We looked at some people's care plans and found they were difficult to read due to the staff members writing style. This meant that staff would not know how to provide care to people as they would not be aware of their needs. Peoples care plans were not personalised, for example the goal for pain management for one person was 'to alleviate pain' and the management was 'to take pain relief medication'.

People who had specific health conditions such as diabetes or who require catheter care did not have any care plans in place to guide staff. The registered manager told us that they were in the process of updating care plans as they had identified that they were not personalised however due to a lack of staff they had not been completed yet.

A person told us that they had a life limiting condition and they were about to undergo significant treatment to manage the condition which could involve side effects. The person told us that the staff had not discussed this with them and was concerned that there was not a care plan in place to manage this. We spoke to the nursing staff and they were not aware of the possible side effects of the treatment.

Pre-admission assessments were not robust. They lacked detail and found that some information was missing.

The lack of person-centred assessment of needs and preferences meant that people did not receive care and treatment that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's concerns, experiences and complaints were not always acted upon. People, their relatives and health professionals told us that they had spoken to the registered manager to raise concerns regarding care plans not being updated, people not receiving care to meet their needs, lack of staffing, waiting times for call bells and lack of staffing training. People advised that their concerns were not listened to and nothing had been done to improve the situation. The register manager did not routinely keep a record of complaints. There was only one complaint recorded in the complaints log and this was dealt with at the provider level and was dealt with satisfactorily. The registered manager told us that the home acted on concerns and tried to deal with them at the time. Recording complaints would ensure that the manager can put things right, identify trends; learn from events and feedback to the complainant.

The registered manager did not act on complaints and concerns raised by people, their relatives and health

professionals. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above one relative told us that staff had suspected their relative had an infection and tested quickly and ensured that the person received the right treatment. The relative went on to say that "X had wanted to have their medication at a certain time otherwise they became anxious and staff ensured that their medication routine was changed to help reduce their anxiety."

People had some activities they could join in if they wished. One person said "There is not a lot going on, I wish there was more." This person told us that they used to go bowling weekly; this had not been explored by staff. Other people told us they did not want to join in with the activities, because they were happy doing their own thing. There was an activity timetable in place for people; activities included arts, crafts, exercises and cooking. There was at least one activity a day. An activity occurred the afternoon on the inspection which involved people making chocolate chip cookies in the dining area. We observed the activity co-ordinator visit people in their rooms to encourage people to attend. We heard the activity co-ordinator tell people that a library trip had been arranged for later that week.

Inadequate

Is the service well-led?

Our findings

The management of accidents and incidents was no robust. The registered manager did not have oversight of incidents and accidents which meant that patterns or trends were not identified. For example, one person had a number of unwitnessed falls. There was no record of what action was taken, such as a referral to falls clinic or discussion with GP about how this could be addressed. We checked this person's care plan and there was a falls diary, but no mention of follow up action regarding the falls.

The homes accident and incident policy was not followed. This stated that the registered manager would review the facts and 'will take those actions necessary to minimise danger of the same accident/incident in future. These actions should be noted on the form.' The registered manager told us "I know there is no analysis of incidents and accidents and I am aware of the need for robust auditing." As the registered manager had no oversight of incidents and accidents they were unable to identify trends, learn from events and appropriately manage high risk situations.

There were no robust systems in place to audit the quality of care provided. The homes quality assurance policy stated that quality is a 'continuous improvement must be maintained by way of regular auditing and reviewing of the standards of performance in all aspects of the organisation and its personnel.' The policy did not give guidance as to what processes were to be used and how regularly quality assurance systems should be used. We asked to see documentation for any quality assurance audits however, we were not provided with any. Therefore the registered manager and registered provider were unable to monitor, evaluate and improve the quality of care that was provided. The registered manager told us "I know there are no quality assurance systems in place at the moment, I won't ignore it."

The registered provider and registered manager lacked oversight as to the day to day and on-going issues at the service. The registered provider had commissioned two external quality assurance audits that had been competed in July and August 2015. The audits identified similar areas that required improvement; however the recommendations from either report had not been acted upon. The audits had not identified breaches of regulations that have been identified in the inspection. The auditing process and the lack of management oversight from the provider was not robust enough to drive improvements in quality of care.

Staff meetings did not occur on a regular basis. Having regular staff meetings would enable staff and the provider to work together to identify areas that needed to be improved so that people received quality of care. Staff had not received an appraisal. Appraisals would enable staff and management to review performance and discuss areas of staff development to improve quality of care and to value staff. The registered manager told us it was difficult to provide this as there had been a high turnover of staff and they had not been able to focus on delivering high quality care.

There were no routine systems in place to obtain feedback from people, staff, relatives and visiting professionals. Residents and or relatives meetings did not occur regularly. This meant that the opportunity to continually evaluate feedback from people and those that matter to them to improve the service were missed.

The provider did not have effective and robust procedures in place that enabled the registered provider to assess, monitor and improve the quality of care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service worked closely with health professionals. They told us that they have provided a lot of support to the staff at the home to ensure that people received safe and effective care. They told us that until recently they had a good working relationship with the management of the home and that people and their relatives had positive experiences of the care being provided. However they told us this had changed recently following safeguarding concerns being raised. The registered manager told us that they had good working relationships with other agencies and was keen to take up their support, guidance and training that they offered.

There was a 'residents and relatives' meeting three months prior to our inspection. The provider told us 30 plus people attended. One family member told us they had attended, people told us they did not know of any meetings. However we asked the registered manager for the minutes of the meeting, none could be provided.

Ten customer feedback questionnaires had been completed over an eight month period; the majority of them were completed by relatives. Most of the forms had positive comments.

The registered manager told us that she had not received any regular supervision or support from the provider. However they told us that they felt supported by them. Since the inspection the provider has put in additional support to help the registered manager ensure that they were able to improve the quality of the service.

People told us they knew who the registered manager was and staff told us that they were supportive. The registered manager told us that they were visible 'on the floor' on a regular basis and spoke with everyone to find out how they are and if they have any concerns. The registered manager told us that they wanted to "overcome the challenges of recent, move forward and provide excellent care."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or ill treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager did not always act on complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the right training and skills to support and care for people.