Acegold Limited

Carlton Mansions 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?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 29 November 2016 and was unannounced. The last full inspection took place in November 2015 and, at that time, two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to need for consent, person centred care and good governance. 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 24 people living in the home.

There was no registered manager in place on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager's application is currently being processed.

At our last two inspections we found that the care plans were not sufficiently detailed to help staff provide personalised care based on current needs. Insufficient improvements had been made. This area of their work requires further development.

Medicines were not consistently managed safely. Topical medicine charts were in place, but they had not in all cases been consistently signed by staff to indicate that people had their lotions and creams applied as prescribed. One staff member who administered medicines did not have a full understanding about creams and their expiry date. They also didn't know about the specifics of administering one medicine they had given as part of the morning's medicines.

People's nutritional and hydration needs were not consistently met. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. There were gaps in some of the food and fluid charts in place and the fluids were not totalled. Where there had been a low intake there was no evidence that the information had been noted and escalated to a senior member of staff.

At our previous two inspections we found that people were not always safe, as there were not always sufficient numbers staff to support their needs. We found that sufficient improvements had been made.

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

A range of checks had been carried out on staff to determine their suitability for work. Staff were supported through an adequate training and supervision programme.

People had access to on-going healthcare services. Records showed when people were reviewed by the GP, district nurse and the dementia well-being team. Referrals for advice and support were made in a timely manner and when people's needs changed.

People told us that staff were in the main caring and respectful. Comments from people and relatives included, "The staff are all lovely here, they work hard"; "I think they look after everyone as best they can I would recommend it definitely"; "She's a top lady [care assistant] and she's as good as gold."

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.

Since the previous inspection the service has appointed a new manager and deputy manager. Staff, people and relatives held them in high regard.

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

We found three 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not consistently managed safely.

Records showed that a range of checks had been carried out on staff to determine their suitability for work.

Staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutrition and hydration needs were not consistently met.

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.

Staff were supported through an adequate training and supervision programme.

People had access to on-going healthcare services.

Is the service caring?

Good

The service was caring.

People told us that staff were in the main caring and respectful.

Staff told us how they provided care and support that was kind and respectful and how they made sure people's dignity and right to privacy was maintained.

Staff were knowledgeable about people's individual needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently written in conjunction with people or their representative.

The provider had systems in place to receive and monitor any complaints that were made.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

This is the third inspection that the provider of Carlton Mansions has not fully met all the regulations. This has included one repeated breach of the person-centred care regulation.

Since the previous inspection the service has appointed a new manager and deputy manager. Staff, people and relatives held them in high regard.

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 9 November 2016 and was unannounced. The last full inspection took place in November 2015 and, at that time, two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to staffing and person-centred care. The service was rated as 'requires improvement'.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

Before the inspection, the provider completed a 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 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 12 people that used the service, three relatives and 12 members of staff. We also spoke with

the deputy and regional support manager.

We reviewed the care plans and associated records of five people who used the service. We observed the medicines round and 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

Medicines were not consistently managed safely. Ordered and returned medicines and records seen were well kept. We observed the senior staff member administering medicines safely. They had been trained, shadowed and been observed by the deputy manager before administering medicines alone. The medicines trolley was locked at all times. This ensured that no unauthorised person could access the medicines. No one was self-medicating and Medicine Administration Records (MAR's) had been signed to indicate medicines had been administered as prescribed. PRN (as required) protocols were in place to inform staff when people might require additional medicines such as pain relief.

Topical medicine charts were in place, but they not in all cases been consistently signed by staff to indicate that people had their lotions and creams applied as prescribed. In some cases the instructions were not clear and stated apply 'as directed'. The recording gaps could be that staff didn't know the frequency so creams were not applied consistently. For one person the instructions were not being followed. One topical medicine was required to be applied twice a day and another three times a day. In both instances they were applied once a day over the reviewed three day period.

Drugs were checked and stock was held securely. We did identify that one drug was not stored correctly. The deputy manager was aware of this and told us she would rectify this. The member of staff administering medicines understood about storage temperatures and all records were up to date.

One staff member who administered medicines did not have a full understanding about creams and their expiry dates. Creams were also not dated when opened. We advised the service to obtain a list and display in the medicines room for reference. The staff member also didn't know about the specifics of administering one medicine they had given as part of the morning's medicines. We advised the deputy manager to make this clear for staff. There was only a one hour gap between the end of the morning medicines administration and the start of lunchtime medicines round. This potentially increased the risks people being given medicines at the wrong frequency without the required time elapsing between doses. We advised the deputy manager to check this. Internal and external medicines audits were undertaken and they highlighted that all actions had been implemented.

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

At our previous two inspections we found 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 sufficient improvements had been made.

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The dependency tool determined that the day time cover should be 3.3 care staff and 2.6 staff during the night time cover. Staffing rotas viewed from 31 October to the 29 November demonstrated that staffing levels were in the main maintained in accordance with the assessed dependency needs of the people who

used the service. We were told by the deputy manager that the service aims to provide one senior care assistant and four health care assistants during the day. One senior care assistant and two health care assistants was the aim to cover the night time shift. Short term absences were covered by the existing staff on shift. On the day of our inspection one member of care staff failed to turn up for work and the previous night shift the senior care assistant failed to turn up. To ensure everyone received their medicines the deputy manager told us they covered for the senior care assistant.

Although staffing levels were maintained in accordance with the dependency tool we received mixed comments about the staffing levels. Comments included; "It's alright sometimes. It's fine when we're fully staffed. Last minute sickness, it's hard to find someone"; "Saturday and Sunday is a bit iffy breakfast can be served midday"; "It's hard getting staff to work weekends"; "Not always"; "At times there is"; "They work hard to keep me well." The service had also received two formal complaints regarding staffing levels.

The staffing rotas demonstrated that staffing levels during the weekend were lower than the weekday cover. We also found exceptional days where three staff were providing cover rather that the determined staffing level of 3.3 staff. Agency staff were used to cover for staff on planned leave. The deputy manager told us that the service had recently experienced a number of staff leaving and recruitment is something they're working on.

Risks to people using the service were managed appropriately so that people were protected from harm. The care plans we looked at gave clear guidance and information to staff on how to reduce risks to people whilst also supporting their independence, as far as possible. Examples of risk assessments that we saw were falls, skin integrity, moving and handling, choking and nutrition. All were completed, regularly reviewed and related to the care plans and specific to the needs of the person.

One person had a fall from their bed. Following this the falls risk assessment had been updated, falls monitored and action taken to reduce the effects of any further falls with the use of a more suitable bed and a specialist mat beside the bed. Moving and handling risk assessments were in place and reviewed monthly and any changes identified. Where people had been identified at risk of choking we could see that they had been referred to Speech and Language Therapist and the advice was documented in the care records.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms clearly identified the nature of the incident, immediate actions taken and whether any further actions were required, such as the need to refer to a health professional and updating the person's care plan and risk assessment

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults. Where a potential risk had been identified it was effectively managed. This involved providing extended training, regular supervision and being mentored during the probationary period.

The staff we spoke with had a good awareness and understood their responsibilities with regard to safeguarding people from abuse. They were able to explain the actions they would take if they suspected a person was being abused. One person had a large bruise to their right upper arm. They told us that they had fallen out of bed. The bruising had been recorded, but was recorded as unexplained by the service. A safeguarding alert had not been considered by the service.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

People were cared for in a safe and clean environment. Staff knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons were available. We observed staff using PPE at the appropriate times, such as assisting people with personal care and the lunch time service

We asked people whether they felt safe and well looked after. Comments included: "One or two are alright"; "They look after you everyone is friendly we have games"; "I am safe"; and "There's always someone around."

Requires Improvement

Is the service effective?

Our findings

People's nutrition and hydration needs were not consistently met. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. There were gaps in some of the food and fluid charts in place and the fluids were not totalled. Where there had been a low intake there was no evidence that the information had been noted and escalated to a senior member of staff. Records also showed long gaps between food and fluids, such as from tea time until breakfast time. For example, one person unable to manage their own drinks and meals was at risk of receiving insufficient fluids. On 26 November 2016 their records showed a total of 835mls over 24 hours and no breakfast, 27 November 2016 was 930mls, 28 November 2016 was 340mls. There was no record of the amount of fluid to be provided for this person. Current government guidance on drinking enough to stay hydrated recommends people aim for 6 to 8 glasses of fluid each day (1500-2000mls). People in bed were found with half full cups of drinks so may not have had the fluids recorded correctly. The lack of information meant there was a risk that people might not have enough to eat or drink.

We observed that there was a water and juice dispenser in the communal area, but we did not see people go and get themselves a drink. People were not prompted or asked if they wanted fluids outside structured serving times. People in the main relied on staff to provide them with food and drink. In the room where the dispenser was based one person told us; "Could do with more fruit juice." We requested water and were told it was in the lounge. No cups or glasses were available by it and the water dispenser was empty.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Textured diets were included in care plans. We spoke with the chef who had a good knowledge of the dietary needs of the people. Each person had their own food passport which highlighted their food preferences and dietary requirements. The food was nutritious and served at the correct consistency according to the person's needs. People provided positive feedback about the food. Comments included: "I eat the food it's a good standard"; "Lots of food, marvellous"; and "I get on well with the food though I don't like pasta."

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw 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. 87% of the staff had received MCA training and understood they needed to obtain consent from people before they provided support with personal care or treatment.

We saw that mental capacity assessments had been carried for various aspects of people's care such as supporting a person with their medicines and personal care. However, in one of the care files we viewed one person had sensor equipment and hourly night time checks. There was no decision recorded to show that

the decision had been made in the person's best interests or involved the relevant parties. With the sensory equipment, there is a potential impact on the person's privacy and also a risk that it can be used as a form of restraint. It is therefore important that their use is considered carefully. The deputy manager agreed to take this forward.

Staff were supported through an adequate training and supervision programme. Supervision is where staff meet one to one with their line manager. We reviewed staff records which demonstrated that recent staff supervision 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 moving and handling, infection prevention, health and safety, fire safety and safe handling of medicines. The training records demonstrated that staff mandatory training was in the main up to date. Modules that required refresher training were being taken forward by the service. They no longer used e-learning as their main training format. Training was provided by in-house and external trainers. During the inspection some staff attended training in dementia awareness. Staff were positive about the supervision and training they had received. One member of staff told us; "There is a lot of training here; most of it is face to face."

People had access to on-going healthcare services. Records showed when people were reviewed by the GP, district nurse and the dementia well-being team. Referrals for advice and support were made in a timely manner and when people's needs changed. On the day of the inspection the opticians visited the service to conduct checks on people.

Good

Is the service caring?

Our findings

People told us that staff were in the main caring and respectful. Comments from people and relatives included, "The staff are all lovely here they work hard"; "I think they look after everyone as best they can I would recommend it definitely"; "She's a top lady [care assistant] and she's as good as good."

We observed the lunchtime service. Staff asked people if they wanted help and changed one person's clothes that had become marked during lunch. One person was singing whilst walking to the dining room and they were being supported by a member of staff. People were not rushed and where they needed support, this was undertaken sensitively. One person was having difficulties cutting up their food. Staff assisted the person and offered alternative utensils, which they accepted. There was not a great deal of interaction between staff and people. It was reasonably quiet and some people interacted with each other at the table.

Staff asked about people's welfare to ensure they were alright. One person liked bread being served with their lunch and their preference was respected. We were told by staff that people chose their lunchtime menu choice in the morning. At lunch people living with dementia were not shown pictorial indicators of the food. This would enable them to make decide whether they still wanted the same choice selected earlier in the day as it is likely they would not recall this. We were told that if people decided not to eat their selected meal an alternative would be offered. We observed people eating their food with the minimal amount of staff supervision. People appear contented and were enjoying their food. We noted that everyone had blue plastic crockery. When asked why they were serving food on plastic crockery we were told by the chef they were going to review its use. Some people may not need plastic crockery and the service adopted a blanket approach of its use. The chef joined people after lunch seeking feedback about lunch and to have a chat with people. They sat with one person and had a laugh with them and the person clearly enjoyed the attention.

People had good support with their clothes and grooming and were well-presented. To support their grooming needs a hairdresser visited the service on a weekly basis. Six people had their hair cut in the morning.

People said that in the main they were treated with respect privacy and dignity. Bedrooms were personalised and most staff knocked before entering. People's comments included; "Most of the time, this morning a gentle tap on the door, another time the door just burst open but most of the time they are attentive"; "They do their work, most of the time they knock the door."

Staff told us how they provided care and support that was kind and respectful and how they made sure people's dignity and right to privacy was maintained. 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. One member of staff told us; "All have their individual way of doing things. [Person's names] prefer showers and likes a nice shave and having his hair washed. He likes jogger bottoms and tee-

shirts. He mostly likes to spend time in his room and watching TV. He likes Jeremy Kyle and movies. He likes buildings." We spoke with the person and they told us about their career of being a builder and buildings they had built in the area. Another member of staff told us; "I always ask if people want to conduct their personal care themselves. We enable people as far as possible. We ask and prompt people. We ask people what they would like to wear and ask about their routines."

Recent compliments received by the service stated; "Every member of your care staff was so kind to him and we wish we could thank everyone personally"; and "I would like to hope that when [person's name] has to attend respite in the future he can return to Carlton Mansions. This will help with continuity and familiarity; plus you now understand his little ways and how to manage him."

Requires Improvement

Is the service responsive?

Our findings

At our last two inspections we found that the 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. The quality and content of care plans were variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative.

Care records were comprehensive and covered a range of assessed needs. However the care plans were not updated to reflect the reviews, which were carried out regularly. The information was there but was not fully reflective of people's changing needs. The initial care plan was not changed following the reviews and therefore the ones seen were not accurate and the expected outcomes no longer applied. To find the current information you had to look at the last review entry, which whilst adequate as a review was not detailed guidance for staff.

One person displayed behaviour that could harm themselves or others. The documentation in place in relation to how staff dealt with this behaviour was not robust and did not provide the level of detail required to demonstrate that staff were knowledgeable about how to deal with these incidents. The incident was recorded but there was no reference to previous behaviour or sufficient guidance for staff to follow to reduce the risk of this happening again or what action to take if there were further episodes.

To protect their skin integrity one person had an air flow mattress and adjustable bed. Their mattress was set to the correct level. However they remained on their back, with the head of their bed raised, throughout the inspection and their positioning charts showed this was the case most of the time. Their care plan stated they should be repositioned four hourly at night but there were no records that this was done. The persons had pressure ulcers to both heels and a third ulcer developed in October 2016. The care provided was not responsive to the person's needs and there was a risk of further pressure area damage.

When people had been assessed as being at high risk of pressure area breakdown wound care plans were in place and these were clear and well written. There were body maps in place to enable the review of the wound. The District Nurse managed wound care and this was recorded. In addition, SSKIN bundles were in place which is a nationally recognised five step model for pressure ulcer prevention. The deputy manager had recently received a compliment from the district nurse regarding their care of one person's skin tear on their hand.

People were not consistently involved in their care plans or in the reviews and were in the main staff-led. Although the plans we looked at had all been reviewed monthly and included quotes from people, there were no consistent records to show whether people had been asked if they felt the plan met their needs. There was also nothing to indicate if relatives had been invited to be involved in care plan reviews. However, it was clear from care records that relatives were kept well informed about people's care.

We were told by the deputy manager that the service had introduced a regular 'resident of the day' system

which will focus on a particular person on a rotational basis. The family of the person will receive an invite to attend the service to speak in person about their family member. The person's care plan will be audited and will spend time to speak with key departmental heads such as the manager, the chef and housekeeping to ensure the service is sufficiently meeting their needs. The system not yet been fully implemented and people and relatives told us they were not yet routinely involved in formal care plan reviews. Only one person we spoke with had knowledge of their care plan.

There was good life history recording and previous hobbies and interests were captured but these weren't reflected in people's care plans or in practice. There was a noticeboard in the hall but activities were not displayed for people to be informed. Activities observed during the inspection were not person-centred and records showed it was often the same thing offered, such as playing catch and skittles. As the majority of people were living with dementia best practice in this area had not been developed. The files had a 'meaningful activities record' which gave staff clear instructions about completion but these were not followed. All the records seen were very similar and focused on tasks carried out by staff, such as, 'happy for me to tidy wardrobe', '[Person's name] has loved spending some time in his room this week' and 'enjoys all his meals.' There was no evidence of any social stimulation for the people cared for in bed.

We received mixed comments about the activities. These included; ""I would like to go out more. I would relish walks fresh air keeps you healthy. I have suggested a choir as singing together is good for you"; "We went to the zoo the other week"; "It's good from what I have seen and heard. There is music, games and lots of knitting. My mum likes knitting" Some people came to train the staff on dementia awareness therapy. They sat with some of the residents and gave them some tactile objects. They told us they would come back again to train staff.

The action plan stated that all care plans would be written in a person-centred way and reflect personal preferences by July 2016. This continues to be work in progress. There continues to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People and their relatives told us they had no cause for complaint.

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.

Requires Improvement

Is the service well-led?

Our findings

This is the third inspection that the provider of Carlton Mansions has not fully met all the regulations. This has included one repeated breach of the person-centred care regulation. Additional concerns have also been identified. They relate to the management of medicines and meeting people's nutrition and hydration needs. Since the previous inspection in November 2015 the service has failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. An example where they failed to implement the action stated in their plan included; "New Brighterkind care plans are being implemented, these are being completed in a person-centred way this will ensure all staff are aware of individual care needs and preferences." Their action plan stated that the actions would be completed by July 2016.

Since the previous inspection the service has appointed a new manager and deputy manager. Staff, people and relatives held them in high regard. People we spoke with felt well cared for. Relatives told us they would recommend the service to others. Comments included; "She [manager] supports staff and knows what it's like to be a carer. I look up to her"; "The care is good and the management are supportive"; "I think they look after everyone as best they can I would recommend it definitely"; "I love it. It is perfect I saw thirty care homes before coming here."

The manager communicated with staff about operational issues. Recent agenda items identified action points which needed to be taken forward such as the importance of recording information in food and fluid charts breaks and the need to adhere to the infection control policy. Issues also discussed were safeguarding and the whistle-blowing policy. Staff told us they felt listened to.

The regional manager visited the home regularly and compiled a monthly visit report. Issues reported on included; pressure ulcers, weight loss, staff feedback, resident involvement, staffing and sickness. 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 taken forward within the required timescales. The October 2016 report had also identified issues regarding the management of medicines and the required actions the manager and deputy manager needed to address. The report also noted that infrequent staff meetings were held. Following the report two staff meetings had been held in November 2016.

Unannounced night-time visits were also conducted by the deputy manager and manager and other staff members employed by the provider who managed other services. Verbal and written reports were provided regarding the observations made and actions required.

The provider sought feedback from people so that they could evaluate the service and drive improvement. A recent resident and relatives meeting had been held which enabled an open forum for discussion and enabled people to express their opinions. Activities, keyworkers and meals were discussed. At the meeting held in September 2016 people were advised that more outdoor activities would be offered and their keyworkers would take them out.

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 last survey report was published 7 October 2015. The service received 5 responses which was a response rate of 25%. People rated the service very highly on the level of care, staff, food and housekeeping. Areas which didn't rate highly were the interior of the building and the activities. Since this survey an activities coordinator has been appointed. The dining room has been moved to another area of the service and the communal area has been extended.

To ensure the safety of the service regular fire, water, health and safety checks were undertaken. Where improvements were required they were undertaken within the designated timescales set by the management team.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not sufficiently detailed to help staff provide personalised care based on current needs. Care plans were not consistently written in conjunction with people or their representative.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not consistently managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutrition and hydration needs were not consistently met.