Eastgate Care Ltd

Park House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17 and 18 March 2015 and was unannounced.

Accommodation for up to 68 people is provided in the home over two floors. The service is designed to meet the needs of older people and has a separate unit for people living with dementia.

At the previous inspection on 7 August 2014, we asked the provider to take action to make improvements to the areas of assessing and monitoring the quality of service provision, cleanliness and infection control, safety and suitability of premises, consent to care and treatment, records and staffing. We received an action plan in which the provider told us the actions they had taken to meet the relevant legal requirements. At this inspection we found that concerns remained in most of these areas.

There was a registered manager in place. However, they had left their position at the end of February 2015. One of the provider's representatives was acting as interim

Summary of findings

manager at the time of the inspection and was present throughout the inspection. A manager had been appointed but had not started at the time of the 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.

People told us they felt safe in the home; however, we found that processes were not always followed to protect people from the risk of abuse. Systems were in place for staff to identify and manage risks; however these were not always followed. People and staff told us and we found that there were not enough staff on duty. Staff were recruited safely. People told us that they received medicines when they needed them. However, we found that staff did not follow safe medicines management and infection control processes.

People told us that staff knew what they were doing and we found that staff received induction, training and supervision. People told us that staff explained to people what they going to do before providing care and we found that the requirements of the Mental Capacity Act 2005 were adhered to. People told us that they enjoyed the food but we saw that people were not always fully supported at mealtimes. We saw that the home involved outside professionals in people's care as appropriate, however, actions were not always taken to ensure people were fully supported to maintain good health. We saw that limited adaptations had been made to the premises to support people living with dementia.

Most people and their relatives told us that staff were kind and caring and we saw that staff were kind and compassionate. However, we saw that staff did not always respect people's privacy and dignity and people's diverse needs were not always met. We found that relatives and some people who used the service were involved in making decisions about the care and support they received.

People told us that they had to wait to receive care and we saw that needs were not always promptly responded to. People told us that activities were offered but staff told us and we found that activities required improvement, especially for people living in the dementia unit. Care records did not always contain sufficient information to provide personalised care. People told us they knew how to make a complaint but it was not clear whether staff had recorded complaints when they had been made.

People and their relatives could raise issues at meetings or by completing questionnaires but actions to address concerns were not clearly documented. The registered manager was no longer in post but a new manager had been appointed. There were systems in place to monitor and improve the quality of the service provided; however, these were not always effective. The provider had not identified the concerns that we found during this inspection and had not addressed issues identified at our previous inspection.

We found a number of 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?

Inadequate

The service was not safe.

Appropriate action was not always taken to make sure people were protected from the risk of abuse. Accidents and incidents were not analysed to ensure that they did not happen again. The premises was not always managed to keep people safe.

Staffing levels were not sufficient to meet the needs of people who used the service and safe infection control and medicines management procedures were not followed at all times, however, staff were recruited by safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff involved other healthcare professionals if they had concerns about a person's health, however, systems to ensure that people maintained good health were not always followed.

People were not consistently supported to eat and drink at mealtimes and limited adaptations had been made to the premises to support people living with dementia.

However, staff received induction, training and supervision and explained to people what they were going to do before they provided care. People's rights under the Mental Capacity Act 2005 were protected.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not always respected. People's diverse needs were not always respected.

Staff were compassionate and kind. Relatives and some people were involved in making decisions about their relative's care and the support they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not always promptly responded to and people were not supported to maintain hobbies and interests. Care plans were generally in place outlining people's care and support needs however, they did not always contain sufficient information to provide a personalised service.

Complaints processes were in place but it was not clear that these had been followed when complaints had been made.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Audits carried out by the provider had not identified all the issues found during this inspection. Issues identified at our previous inspection had not been addressed.

Systems to ensure people and relatives were involved in the development of the service were not fully robust and the registered manager was no longer in place.

Park House

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 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 17 and 18 March 2015 and was unannounced.

The inspection team consisted of three inspectors and a specialist nursing advisor with experience of dementia care.

Before our inspection we reviewed all the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with five people who used the service, two relatives and a health and social care professional. We spoke with the administrator, seven care staff, one nurse, the acting manager and two representatives of the provider. We looked at the relevant parts of eight care records, three recruitment files, observed care and other records relating to the management of the home.

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

Inadequate

Is the service safe?

Our findings

When we inspected the home in August 2014 we found concerns in the area of safety and suitability of premises. At this inspection we found that concerns remained in this area.

Risk assessments were in place where appropriate. However, accident and incident forms were not fully completed. Forms were not always signed and actions taken to prevent re-occurrence were not completed. One of the provider's representatives told us that there had been no effective analysis of accident or incident forms. This meant that there was a greater risk of similar incidents being repeated as they had not been correctly investigated and actions recorded to prevent re-occurrence.

We saw there were plans in place for emergency situations such as an outbreak of fire. A business continuity plan was in place in the event of emergency. We saw that a personal emergency evacuation plan (PEEP) was in place for people using the service. However, premises and equipment were not always managed to keep people safe. We saw that potentially harmful materials were unattended including coconut shower gel, adhesive, pipe freezer spray and nail varnish remover. We saw that the first floor bathroom's window restrictor was broken. We saw another bathroom on the first floor was being refurbished and the door was unlocked and the window restrictor had been taken off. Fire extinguishers were not always fixed to the wall. Some raised toilet seats were unsteady. One dining room chair was missing arms and had exposed screws. Outside clinical waste containers were not secure. This put people at risk of harm.

Appropriate checks and maintenance of the equipment and premises were not always taking place. Five year periodic testing of the electrical system had not taken place and there was no legionella risk assessment in place which meant that there was a greater risk of people being put at risk of avoidable harm.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in August 2014 we found concerns in the area of staffing. At this inspection we found that concerns remained in this area.

Three people told us that there weren't enough staff; one person told us there were enough staff. One person said, "When I needed the toilet yesterday no-one was around. It's worse at weekends." Another person said, "Definitely not [enough staff]. It can take 30 minutes for your buzzer to be answered." A relative told us that there were not normally enough staff which led to a delayed response from staff. Another relative told us of their concerns regarding staffing on the dementia unit, "There should be two staff, most times there is only one and then they have to go out leaving the lounge unattended." Staff told us that there were not enough staff on duty. They were particularly concerned about staffing levels on the dementia unit. One staff member said, "No there is not enough staff; we need four staff all the time, we work with three staff most of the time."

We looked at completed timesheets which confirmed that the provider's identified staffing levels were not always being met as one shift in the previous week had been short staffed. We observed that non-care staff were sometimes the only staff member supervising people on the dementia unit lounge. The home had a nurse call system which monitored the time taken for calls to be answered. We asked for a print out of recent calls and this print out listed a number of times where people were waiting between 10 and 29 minutes for assistance in response to calls. This suggested that there were insufficient staffing levels to meet people's needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in August 2014 we found concerns in the area of cleanliness and infection control. At this inspection we found that concerns remained in this area.

One person said, "The home is clean, spotless." However, a staff member spoke to us about the dementia unit and said, "It's not clean enough it needs its own cleaner." We found that the dementia unit was not clean. The floors in the main communal area were not clean and walls were

stained. The only downstairs communal toilet for the dementia unit was not clean and the tap was broken so people living with dementia would find it very difficult to wash their hands.

In the rest of the home we saw that some bathrooms were unclean. We also saw continence pads stored out of their packaging and syringe tubes were not stored appropriately so that they would stay clean. We also saw dirty bedroom walls, a stained armchair, an unclean mattress and overlap table, a stained commode frame, a ripped commode cushion, and an unclean commode pot. This put people at risk of infection.

We saw that a person had an infection. Staff were not following guidance from the hospital consultant regarding managing this infection. No information regarding the infection was noted in relevant care plans. This put people at risk of infection.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. One person told us they got medicines on time. Another person told us that they received pain relief when they needed it. However, a relative told us at 2.30pm that their relative had just received their morning medicines.

We observed that people received their medicines safely downstairs. However, we saw that a medicine trolley had been left unattended upstairs with 'potted up' medication on the top of the trolley with names of people who used the service on a small piece of paper placed in each medicine pot. This meant that medication errors were likely to occur, as the medication could not be identified once it was placed in the pot and there was a risk that a nurse could not clearly identify the person for whom the medication was intended by the handwritten name in the medicine pot. We raised this issue with the acting manager and the nurse was immediately suspended from giving medicines.

We saw that medicines were not always stored securely. The room where medicines were stored was locked but the key had been left in the lock of the medicines' fridge. We also observed that a medicines trolley had been left unattended in the lounge next to an open exit door close to a public road. The temperatures of the room and fridge where medicines were stored were checked daily and staff had received medicines training and had their competency assessed to give medicines. However, we saw that some controlled drugs had gone missing and no incident form had been completed and no investigation had taken place. This meant that appropriate actions may not have been taken to prevent re-occurrence of this incident.

We read the Medicine Administration Records (MARs) for ten people who used the service. We noted a medication error where an antibiotic prescribed four times a day had been administered three times a day over 10 days. This meant the prescription had not been administered correctly and may have placed the person at risk of harm. The provider had not identified this error prior to us bringing the matter to their attention. We also saw that a person had not received their medicines at their prescribed time. This person had a condition which meant it was important that medicines were received at the correct time. We saw that prescribed creams and food supplements were not always stored appropriately and documentation was not fully completed to evidence that prescribed creams were being applied to people.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home and would know who to speak to if they had any concerns about their safety. A relative told us that people were safe. One staff member told us that people were not always safe. Staff had attended safeguarding adults training and the safeguarding policy and procedure contained appropriate detail. We saw safeguarding information displayed on a noticeboard in the reception and in the guide for people who used the service so people and their relatives knew who to contact if they had concerns.

Unexplained marks and bruises had been recorded for two people but full investigations had not been carried out into why the bruises and marks had been sustained by the person. We also saw that a safeguarding referral had not been made to the local authority when required. We saw that one person who used the service had thrown a cup of tea over another person but this had not been referred to the local authority. This meant that there was a greater risk

Inadequate

Is the service safe?

that potential abuse had not been investigated thoroughly and actions taken to address concerns. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed that staff did not always safely support people. We observed that one person was left hoisted in mid-air for approximately five minutes as staff were not sure what to do next. This put the person at risk of harm.

People were recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. Appropriate checks had been carried out before a staff member started work.

Requires Improvement

Is the service effective?

Our findings

When we inspected the home in August 2014 we found concerns in the area of safety and suitability of premises. At this inspection we found that concerns remained in this area.

We saw that limited adaptations had been made to the design of the home to support people living with dementia. Staff raised concerns about the suitability of the dementia unit. One staff member said, "The area is too small. I would like to see some outside access for [the people who used the service]." Another staff member said, "It's a poor design. Everyone is squashed in together and the dining area is poor, it's not pleasant."

There was orientation information available for people which was clearly displayed showing the day and date. However it showed the wrong day and we heard one people saying on Tuesday that, "It's Monday isn't it, if that's what it says it must be." There was no directional signage to support people to move around the dementia unit independently. We observed people wanting to leave the dementia unit and access the garden area but they could not do this easily. The lift to go upstairs to some bedrooms on the dementia unit was only accessible through key pad doors so people could not access it independently. Only one of three downstairs toilets could be accessed by people who used the service on the dementia unit. One was being used by staff and one was being used as storage. We overheard two people waiting to use the toilet and saying that they couldn't open the two other toilet doors. The lounge area was very full with chairs. This meant that people on the dementia unit were not living in a suitable environment to meet their needs.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the food they received. One person said, "The food is excellent." They told us that they got enough to eat and drink. Another person said, "I love my cups of tea and there's always a drink at the table. The food looks nice but I'd like a bigger plateful." Another person said, "The meals are nice and I get a lot to drink."

However, a relative said, "The food has got worse, it doesn't look appetising. They [staff] support [my relative] at mealtimes but they don't always wake other people up at mealtimes."

We observed lunchtime downstairs on the main unit. We saw that people were offered a choice of drinks and meals were explained to them. People were offered alternatives if they didn't like the main meals. We observed that people were appropriately supported by staff and encouraged to eat. However; there was only one staff member to serve food and assist people to eat on the top floor. Food was cold and looked congealed by the time it was served. A person upstairs told us they did not enjoy the food on offer and told us it was frequently served cold.

The lunchtime experience on the dementia unit was poor. Table clothes did not fit the dining tables and people were given their meals with gravy and sauce added without people being asked first. All people were given the same desserts with no choices offered. We asked one person what they were having for tea. They said, "I don't know what I'm having they usually just give it to you." This meant that people were not always offered choices regarding their food to support them to eat sufficient to meet their needs.

Two people told us that they saw the doctor when they needed to; however, one person told us that they had asked to see the doctor three times but they had not seen them. A relative told us that the Doctor came quickly to visit their relative when needed. We saw that one person's care record showed that the person was due to have a social care review in January 2015. However, the review had not taken place and the provider had not pursued it even though the person wanted it to be undertaken. However, other care records showed that other health and social care professionals were involved in people's care as appropriate. We looked at the care being provided for a person with diabetes and saw that staff were supporting them appropriately.

We looked at the care records for people at risk of skin damage. We saw that one person was identified as requiring a specific cushion for sitting in a wheelchair. We saw that the cushion was not in place. Another person with a pressure ulcer did not have a wound care plan in place and their repositioning charts were not fully completed to

Requires Improvement

Is the service effective?

show that the person was receiving care in line with their care plan. We saw that one person was noted to have an open wound to one knee but no wound care plan was in place.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in August 2014 we found concerns in the area of consent to care and treatment. At this inspection we found that improvements had been made.

People told us that staff asked for their consent before providing care. A relative told us that staff explained what they were doing when helping people. We observed staff generally explained to people what they were going to do, before they provided care. However we observed that staff did not talk with one person when they were transferring them.

Staff had an understanding of the requirements of the Mental Capacity Act (MCA) 2005, an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability. We saw assessments of capacity and best interests' documentation were in place for people who lacked capacity.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. We saw that a number of people were subject to a DoLS and appropriate documentation was in place.

We observed how staff responded to people with behaviours that may challenge others. We saw one person repeatedly knocking on doors leading to the garden areas, staff did not respond to this person. However we saw staff responding appropriately to two other people who were displaying behaviours that may challenge others and we saw that two people's care records provided sufficient guidance for staff in supporting them with their behaviours that may challenge others.

We looked at the care records for two people who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place. Both forms were not fully completed. Actions had not been taken to address this issue. This meant that there was a greater risk that the person's rights were not being protected.

One person said, "They are very good staff and work hard." Another person said, "I feel the staff do their best." A relative told us that some staff did not speak English well and felt that this had had an impact on them. They told us that a nurse had told them that their relative was going to die. They had rushed to the home and were told by another staff member that they had merely wanted to arrange a meeting to discuss whether their relative would want to be resuscitated in the future.

Staff told us that they had received an induction and supervision and felt supported in their role. Staff also told us that they had received training but not all staff had received a recent appraisal. We looked at the training matrix which showed that training was generally up to date though not all staff had attended all relevant training.

Requires Improvement

Is the service caring?

Our findings

People told us that they were treated with dignity and respect. However, we observed that staff did not always knock and wait before entering people's bedrooms. We heard a staff member tell a person that they needed to keep the cover over them while they were in bed as they didn't have any bottoms on. The carer then left the room without closing the bedroom door. We heard staff use some terms which did not respect people's dignity and there were no dignity champions identified in the home. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

The side of the home was not secure and could be accessed from the street. Some people's bedrooms were on the ground floor and could be looked into from the side of the building. The dementia unit had windows that could be seen from the car park and back of the building. Upon arrival at the home's car park on the second day we observed a person who used the service standing half naked in a bedroom on the dementia unit. There were no staff nearby to prevent this and the person was standing in another person's bedroom who was an opposite gender to them but not in the room at the time.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person told us that staff were kind. Another person said, "Staff are lovely." A relative told us that staff were kind. They said, "They treat [my relative] well." We observed interaction between staff and people who used the service and saw people were relaxed with staff and confident to approach them throughout the day. Staff interacted positively with people, showing them kindness and compassion. We observed caring and sensitive interactions between care staff and people who used the service.

However, we saw two people with chipped nail varnish and one person wearing trousers that were unclean and stained. Staff were not always able to respond effectively to people living with dementia showing distress which meant that people continued to show distress. One person said, "I want to go out I don't want to sit there." The staff member did not reassure them. The same person was asking staff if they had seen her sister and staff did not respond.

A person told us that staff knew them well. We discussed the preferences of people who used the service with care staff. Staff had a good knowledge of people's likes and dislikes. We saw that a detailed communication care plan was in place to support staff to communicate with a person with communication difficulties.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. This meant that people's diverse needs were being assessed. However, people's diverse needs were not met. Three people received food not in line with their dietary requirements. Two people following a vegetarian diet were recorded as having been served fish or other meat and one person who didn't eat red meat had been recorded as being served beef.

People told us that they had not seen their care plans but were able to make choices about their care. People felt staff listened to them. A relative said, "I've seen the care plan but only recently. As we only found out about the care plan recently we haven't been involved in discussions about the care plan." We saw that two people had been involved in a review of their care and we saw involvement of relatives in people's care. A guide provided for people using the service contained details of an advocacy scheme available for people if they required support.

A person told us that staff encouraged them to be independent where possible and we saw that people were supported to be independent at mealtimes. People told us that their relatives could visit whenever they wanted to. A relative said, "I can visit whenever [I want to]."

Requires Improvement

Is the service responsive?

Our findings

When we inspected the home in August 2014 we found concerns in the area of records. At this inspection we found that concerns remained in this area.

Care records did not consistently contain information on people's individual needs and how to meet them. A number of care plans were standardised and amended by inserting a person's name in them. Care records were not well organised and contained duplicated information. People's preferences were not always noted and their life histories were not always fully completed which meant that their needs may not have been fully identified to allow staff to provide personalised care.

People's needs were not always responded to promptly. A person told us that they regularly waited to receive care. A relative said, "It's usually a waiting game." Records showed that call bells were not responded to promptly at all times.

We asked people whether they were supported to follow their preferred hobbies or interests. One person said, "I get to do what I want." Another person said, "You can visit local places if you want." A relative said, "The activities box is not used, they do some singing and cake decoration but that's about it." We saw that the reminiscence box and the sensory box on the dementia unit were empty.

We observed that the activities timetable did not always specify what activities would be taking place and some sessions were listed as; 'Care staff to facilitate' or 'Annual leave'. We observed activities taking place during our inspection but activities on the dementia unit were very limited. Staff told us that there were not enough activities available for people who used the service. One staff member told us that minimal activities were offered. Another staff member said, "Activities have improved but are still not working."

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person told us that they had a lot of friends living in the home. Another person said, "All my friends are here. I don't want to move anywhere else."

People told us they had no complaints but knew what to do if they wanted to make a complaint. One person said, "I wouldn't be bothered one iota about making a complaint." A relative told us that they made a complaint to the registered manager but nothing had happened. The complaints procedure was displayed in the reception and was also included in the guide provided for people who used the service. A clear procedure was in place for staff to follow should a concern be raised.

We looked at the complaints records and saw there were no complaints listed since May 2014. Staff told us that complaints had not been properly recorded when made.

Inadequate

Is the service well-led?

Our findings

When we inspected the home in August 2014 we found concerns in the area of assessing and monitoring the quality of the service provided. At this inspection we found that concerns remained in this area.

Audits were completed by the manager and also representatives of the provider not directly working at the home. An external auditor commissioned by the provider had assessed the home as 'inadequate' in all areas in February 2015. No action plan had been completed and we saw some of the same issues at this inspection. Audits were not fully completed or action plans were not always put in place to address identified concerns. Some care plan audits had identified issues in October 2014 but actions had not been signed off to show they had been addressed. We identified a number of shortcomings during this inspection which had not been identified by the provider or had been identified but actions had not been taken to address the issues by the time of the inspection. These shortcomings constituted breaches of a number of regulations.

We also saw that a range of issues identified at our previous inspection had not been addressed by the provider.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they had not been asked their opinions about the home. A relative said, "The relatives' meeting was last minute, not enough notice." We saw that a relatives' meeting had taken place in February 2015. However the last meeting for people who used the service had taken place six months ago. We were told that questionnaires had been completed in December 2014 and an action plan was in place. However staff were unable to locate this for us during the inspection so we were unable to judge whether any of the feedback received had been addressed.

We saw that the provider's set of values were in the guide provided for people who used the service. A whistleblowing policy was in place and contained appropriate details. Staff felt that they could raise concerns. One staff member said, "Management are approachable." Another staff member said, "Their door is always open."

One person told us that they felt that they could talk to the manager. A relative said, "The manager listens but then does nothing. You hardly see the managers." We saw that staff meetings had taken place and the manager had clearly set out their expectations of staff. Staff felt that the interim manager was very supportive. One staff member said, "It's a shame she can't stay." Another staff member said, "The interim manager has made a big difference in such a short time, has got us seniors doing walk rounds the home – yes there has been a big improvement".

There was a registered manager in place. However, they had left their position at the end of February 2015. One of the provider's representatives was acting as interim manager at the time of the inspection and was present throughout the inspection. A manager had been appointed but had not started at the time of the inspection. We saw that conditions of registration were being met and notifications were sent to us as required by law.

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 10 HSCA (RA) Regulations 2014 Dignity and respect Service users must be treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must ensure the proper and safe management of medicines and assess the risk of, and prevent, detect and control the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the service provider must be clean, secure, suitable for the purpose for which they are being used and properly maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

The enforcement action we took:
We served a warning notice on the provider with a timescale for compliance of 15 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:
We served a warning notice on the provider with a timescale for compliance of 15 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

The enforcement action we took:
We served a warning notice on the provider with a timescale for compliance of 29 May 2015.