Care Homes UK Ltd

Stockingate Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 26 January 2015. At the last inspection on 18 June 2014 we found the provider was breaching regulation 9, care and welfare of people who use services, regulation 15, safety and suitability of premises and regulation 10 assessing and monitoring the quality of service provision. At this inspection we found some improvements had been made however, the provider was still in breach of regulation 9, 10 and regulation 15. We also found there was a breach of regulation 14 meeting nutritional needs.

Stockingate Residential Home is registered to provide accommodation and personal care for up to 25 persons. At the time of our inspection the home did not have a registered manager. 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.

Summary of findings

We found areas of concern relating to the premises. The new windows at Stockingate Residential Home had window restrictors which could easily be disengaged by hand. We identified this issue to the manager and area manager at the time of our inspection. Since our inspection the window restrictors have been changed to comply with HSE guidance. The area manager said they had consulted others when they installed the new windows and restrictors. There was a trip hazard on the ground floor and repairs to the roof were required. The medication room was too hot and the drugs fridge was overheating.

We found some people's risk assessments did not contain up to date information.

We looked at medication and saw there was a good system in place for the administration of medication. However, we found night staff were not trained to administer medication.

We looked at the recruitment records of four members of staff. We found all the necessary checks had been carried out before commencing employment with the home.

Staff were able to confidently speak about safeguarding and knew what to do should they suspect abuse. People we spoke with told us they felt safe living at Stockingate Residential Home. We found there were enough staff to keep people safe.

We observed the lunch time meal and found some people were not given their food as stated in their care plan. One person was given burger, chips and bread. The burger should have been pureed and the chips and bread cut into small pieces. The burger was not pureed and staff did not cut up the person's food until they had eaten half of it. We found people's food was not fortified if they had lost weight. Staff told us people did not get a choice of food.

We found staff had not received recent supervision meetings although the new manager had instigated a matrix for staff appraisals. Staff told us there was plenty of training and their induction was very comprehensive.

People's care was delivered with consideration given to the mental capacity act and Deprivation of Liberty Safeguards (DoLS). This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. Staff told us they had completed DoLS training.

We looked at the care plans of five people living at Stockingate and found documentation regarding obtaining consent from people in the back of their care records which in three cases had not been completed.

Staff spoke to people calmly and sensitively and seemed to know people well. We saw some good interactions between staff and people who used the service; however, we did see an example of a person having their fingers prised from their cup and fork.

We looked at the care plans of people who used the service and found they were lacking in detail and in some cases there was important information missing.

Staff and people who lived at the service told us they thought the new manager was good and had made some positive changes to the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

We found there was still work required to make the premises safe.

People's risk assessments did not always reflect their current health needs.

Medication was administered safely.

Staff understood safeguarding procedures and would have no hesitation in report any concerns.

Inadequate

Is the service effective?
The service was not effective.

People were not always supported to eat their food as assessed in their care plan. People were not always given choice.

Staff training was comprehensive and most were up to date. However, we found some people's moving and handling and medication training was overdue.

Staff who worked during the night were not trained to administer medication.

Inadequate

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

People were generally treated with dignity and respect although we did see an example of a person not being treated in a caring manner.

End of life care planning was good although it was not always easy to locate the correct document in care files.

Requires improvement

Is the service responsive?
The service was not responsive.

Care plans contained some good information but in several cases did not adequately describe the needs of people.

The activity co-ordinator had left; we were told by staff this meant there was little meaningful activity for people.

There were no recorded complaints; one person who used the service told us "If I say too much I get ignored." This led us to believe some complaints had not been recorded.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

We found several quality audits were carried out but they did not develop an action plan to monitor areas for improvement.

The manager had instigated an audit of people's weight but this only started in September last year so did not highlight where people had lost a significant amount of weight over a longer period of time.

Staff and people who used the service told us the new manager was very good. Staff said the manager was approachable.

Stockingate Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 January 2015 and was unannounced. The inspection team consisted of two adult social inspectors, an estates specialist advisor, a medication specialist advisor and an expert-by-experience with experience of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care 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 any improvements they plan to make. We reviewed information from the local authority and the records we held about the service. We spoke with three people living at Stockingate Residential Home, seven members of staff, the new manager and the area manager. We also spoke with a visiting health professional.

We looked at five people's care records and four people's medication administration records. We observed the lunch time meal and spent time observing care throughout the day. We checked the premises and records relating to the management of the service and safety of the building and equipment.

Inadequate

Is the service safe?

Our findings

During our last inspection in August 2014 we had concerns about the safety of the premises. Whilst we found some improvements had been made during this inspection we found there was still cause for concern.

On the ground floor corridor of the home we found the floor was uneven and a trip hazard to people who used the service, staff and visitors to the home. We identified this to the manager and area manager who told us they would get someone out to look at how to resolve the problem.

We were told by a person who used the service that there had been a water leak in their bedroom. The person had told the provider about this and some repair work had been carried out. However, this had not resolved the problem. Our specialist advisor checked the loft and found holes in the roof. We told the manager about this who said they would get someone out to look at it. We concluded this was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection, the provider had installed new windows throughout the home and each window was fitted with window restrictors. Health and Safety Executive guidance states that 'where assessment identifies that people using care services are at risk from falling from windows or balconies at a height likely to cause harm, suitable precautions must be taken. Windows that are large enough to allow people to fall out should be restrained sufficiently to prevent such falls. The opening should be restricted to 100 mm or less. Window restrictors should only be able to be disengaged using a special tool or key'. The new window restrictors at Stockingate Residential Home could easily be disengaged by hand. We identified this issue to the manager and area manager at the time of our inspection. Since our inspection the window restrictors have been changed to comply with HSE guidance. The area manager said they had consulted others when they installed the new windows and restrictors.

We found the drugs fridge which was situated in the medication room was dangerously over temperature for the storage of drugs, at the time of our inspection the temperature measured at 23C. We found the room temperature was high, due to the extractor fan not working and no external ventilation. We were told by the manager this had been a problem for some time as it was difficult to control the temperature of the room. We saw a monitoring visit document dated 1st December 2014, which stated, 'the fridge and medication room temperatures are recorded daily, some missing, both remain high at times to monitor'. We spoke with the manager about this and during our visit the fridge and medicines were moved to another room. We concluded this was a breach of Regulation 16 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.

We saw there was an up to date medication policy. However, there was no policy for the administration of homely remedies or for medication taken as required. Guidelines for the use of homely remedies and for the administration of 'taken as required' medication should be in place to ensure this type of medication is administered safely.

We looked at the medication records of four people who used the service and found all recordings were accurate and contained a photograph of the person. We observed a medication round. People were given their medicines safely and were assisted where needed. The member of care staff stayed with the person until they had taken their medication. The staff member wore a tabard. We were told staff did not take the medicine trolley around because people moved around a lot. We saw medication was taken from the trolley and the clinical room was locked before people were given their medication.

The medication room had a controlled drugs cabinet, where a smaller locked cabinet was stored for controlled drugs. We checked all of the controlled drugs and found the records were accurate and fully completed.

We saw one person was self-administering insulin and this was recorded in their care plan. We saw the person's blood sugar levels were recorded and where on the body the insulin was administered. A person who used the service said, "I have four needles a day. They're (staff) very good. They're all very competent (to give injections). When I came in here they didn't know how to do it. The lasses have done the training."

Inadequate

Is the service safe?

We found the disposal of medication was carried out by the pharmacy. Drugs for destruction were kept for seven days and then given to the pharmacy. A record book was in place which identified which drugs had been sent back to the pharmacy.

We saw stock control sheets were in place and all drugs were correct, although there was a date at the top of the record sheet, individual dates had not been written alongside individual drugs.

We were told by staff that people could not have medication after 8pm because none of the night care staff members were trained to give medication even though there were a number of people on 'as required' medication. This meant some people who may require analgesia were required to wait for pain relief until an on call member arrived at the service to administer their medicine. We spoke with the management team about this and we were told night care staff would be trained to administer medication. We saw training records and they said 'it was not applicable for night care staff to have medication training'. We concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

We saw risk assessments in people's care plans; however these were not always updated when people's health changed or deteriorated. For example in one person's care plan we saw they had some pressure area damage but the risk assessment tool had not been changed to reflect this. In one person's care plan we saw an accident form which said the person was found sitting on their bedroom floor at midnight 12 December 2014. The document was not signed or dated by the completing person. Two staff had written their names on another area of the document. We looked at a 'Falls history and falls risk assessment' document. Under 'History of falls' dated 18 January 2014 which identified 'No history'. This meant the person completing the risk assessment document had not taken the recent fall into account.

We looked at the recruitment records of four members of staff. We found all the necessary checks had been carried out before commencing employment with the home. We saw evidence of identity checks, for example there were copies of either people's passport or driving licence. There were references from previous employers and also checks made with the Disclosure and Barring Service to ensure staff were of good character and did not have any convictions or were barred from working with vulnerable people.

Staff we spoke with were able to confidently talk about safeguarding and told us they had safeguarding adults training annually. Staff were able to identify circumstances, behaviours and things to look out for which indicate abuse was occurring. They said they would report anything to the manager and would go 'higher' if no action was taken. One member of staff said, they would contact the person's G.P or social worker. Staff were aware of the whistleblowing policy and knew they could report concerns to the Care Quality Commission or the local safeguarding adults unit. A person who lived at Stockingate Residential Home said, "It's like being on holiday, I feel safe here."

People we spoke with told us there were enough staff to keep them safe. We saw there were sufficient staff to meet people's needs and people did not have to wait long for assistance. One member of staff said the number of staff had reduced as there were fewer 'residents', we were told this meant they did not have as long to spend with people as they would like.

Inadequate

Is the service effective?

Our findings

We observed lunch and throughout the day when people were being offered drinks and snacks. We had concerns because people were not given food as detailed in their care plans. We saw one person was given toast for breakfast and for their lunch; they had beef burger, chips and a slice of bread. When we looked at the person's care plan it stated, 'requires assistance, chewing difficulty' and 'unable to eat solid food'. It also said, 'staff to cut up (name of person) food into small pieces, also their meat is to be blended'. We observed a member of staff give the meal to the person who was sat in a small lounge on their own. The food was then left with the person and the member of staff left the room. The beef burger was not blended and the chips were not cut up into small pieces. Another member of staff then came in 10 minutes later and asked the person if they wanted their chips cutting up and then proceeded to cut up the chips and beef burger. The member of staff then left the person again. When they returned they brought a dessert for the person, the person left their main meal and began to eat their dessert. We were concerned because the person had difficulty managing their food and when their plate was taken away a lot of the person's food was in their lap. This meant the person had not had much of their food.

Prior to the lunch time meal we saw there were tablecloths on the dining tables, however, prior to serving lunch these were removed and each person was given a clothes protector. We saw there was a choice of lunch; however, we did not see people being offered choice. We spoke with staff about the lunchtime experience who said, "Lunch is usually soup and sarnies, no cooked breakfasts. People don't get a choice because they don't get asked. They can't choose." And "Evening meals offer limited choice too, only one option available." And "There is no fortification of food. Despite people eating they are losing weight because there is nothing going into the meals. Soup and a sarnie won't help maintain weight." Menus we looked at showed there were no evening meal options available for people, with the exception of one of the menus which showed there was a buffet available in the evening.

People who used the service said, "The food is nice. They asked me what they could do to improve the food. We sat and had a meeting the other day. Sometimes the girls go out for a curry and they ask me if I want one." "You can have what you want for breakfast. Some days we have a light lunch and sometimes you have dinner at lunch." "It's lovely here. The food's lovely."

We talked to the manager about the food available at the home. We were told by the manager there was no system in place for people to make choices about their meals in advance of the meal time occurring. We asked if people who required their meals to be pureed were given a choice of meals. The manager told us there was only one meal choice available for people on a pureed diet. The manager did not know why this was but told us they were planning to speak to the cook about concerns of this nature. We asked if cooked breakfasts were available to people living at the home. The manager told us there was, however, this option was not on the menu or on the menu board in the reception area of the home. The manager told us if people asked for a cooked breakfast they could have one. We were concerned about this as 12 out of 14 people living at the home were living with dementia and may not be able to remember what was available to them. We concluded this was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

The manager had completed a monthly weight audit. We were concerned the weight audit had been carried out from when the new manager took up her post in September 2014 and information prior to September was not taken into account this had not been backdated. We found some people had lost a significant amount of weight in the preceding 12 months but this had not been identified in the weights audit. For example one person had lost 9kgs over a 10 month period but was only being weighed monthly. We could not see this person had been referred to a healthcare professional or that their diet was being fortified in anyway. We spoke with the manager about this on the day of our inspection.

We saw person being assisted to a chair by two members of staff and before the person was able to sit down one of the members of staff said, "I better go and get their (person's name) pressure cushion. The person's care plan and risk assessment did not mention the need for a pressure cushion. We saw there had been a review of the person's care by the local authority which conflicted with information contained in the person's care plan. We

Inadequate

Is the service effective?

concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had not had supervisions or appraisals, one member of staff said they had not had supervision since September 2014. Staff files we looked at confirmed this, however we did see the new manager had implemented an appraisal plan. Regular planned staff supervisions are important as these provide a formal framework to reflect on practice and performance and can be used to identify any training needs or areas of development.

We saw staff had completed a comprehensive induction prior to beginning employment, this covered fire evacuation procedures, fire drills, whistleblowing and job specific topics. One member of staff said, "The induction was really good." We looked at the training matrix and found the majority of staff training was up to date. However, in some cases for example moving and handling, some staff training was overdue by one year and medication training was out of date for two members of staff. It is important that staff competencies are checked and to ensure training is completed within the provider's policies and procedures. Staff we spoke with told us there was lots of training available, one person said, "We do a lot of training, training wise we are kept updated." And "There's a list of training courses in the seniors room."

We looked at the care plans of five people living at Stockingate and found documentation regarding obtaining consent from people in the back of their care records which in three cases had not been completed. We saw there was a note attached to each record which stated 'needs filling in'. We also saw there was a photograph in place at the front of people's care records. However, there was no evidence to say people had consented to having their photograph taken or being used for this purpose.

People's care plans in most cases contained good information about their mental capacity. For example in one person's file we saw a mental capacity assessment under the Mental Capacity Act (2005) had been conducted to ascertain if the person was able to consent to having their medication administered by staff. We spoke with staff about their understanding of the Mental Capacity Act and they were able to tell us how it affected their roles and responsibilities, one member of staff said, "It's all about people being able to make choices and decisions." They said they had been involved in best interests meetings where for example a person had refused care which was having an impact on their health and well-being. Staff we spoke with knew about the Deprivations of Liberty Safeguards (DoLS). This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. One member of staff said they had attended two DoLS training courses in the last six months and the home were in the process of making applications under the DoLS legislation.

Requires improvement

Is the service caring?

Our findings

We saw a member of staff approach a person who used the service to give them a drink, however, before doing so they asked the person for the cup they were already holding. When the person did not let ago they 'peeled' the person's fingers from the cup. On another occasion we saw a member of staff prising the same person's fingers from a fork. During which the member of staff said, "I have to do this or the person (person's name) will hit me with it." We spoke with the manager and area manager about this who were very surprised about our findings. They agreed this should be reported to the local safeguarding authority. We concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Since our inspection we have been advised the local safeguarding authority would not be taking any further action.

During our observations we saw staff interacted well with people who used the service. We saw they were keen to ensure people were happy and had everything they needed. Staff spoke to people with compassion and in a caring manner and where people were unable to respond, staff were involving people positively. Most people were mobile but we saw there were hoists available within the home should they be required. We saw people spent their time in the lounge areas of the home. One person who used the service said, "Everybody's nice. They're (staff) really good. They look after us."

Staff were able to describe how they would maintain people's privacy and dignity during personal care. We saw staff speaking with people calmly; staff seemed to understand people's needs. Where assistance was required staff did so sensitively. We saw in people's care plans what people were able to do for themselves and what they would need assistance with.

Staff told us people could get up and go to bed when they wanted. One member of staff said, "We take pride in what they (people who used the service) look like." We saw people were well groomed and dressed in age appropriate clothing. Someone else said, "It's nice, friendly, warm and homely. We've got a good team of staff here."

We looked at people's end of life care plans. We saw they contained good information about for example where the person would like to be at the end of their life and who they would like present. There was information about their spiritual needs and funeral arrangements. In one person's plan we saw it said, 'would like to be made comfortable and pain free.' We did however, raise concerns with the manager that there seemed to be two end of life documents in people's care files. One called 'Wishes for Terminal illness and End of Life' which we found was completed but at the end of the care file and another titled 'Here are my specific wishes in the event of illness/death', which was in the middle of the file. In most cases we found the latter was blank. This may mean the person would not receive the care they would want to receive.

Inadequate

Is the service responsive?

Our findings

During our last inspection we were concerned that people's care plans did not contain accurate information about the person. During this inspection we found that whilst people's care plans contained some good information they were not always accurate. There were also several areas of people's care plans that were blank or were not adequately completed.

In one person's care plan in the 'Social interests, hobbies and religious & cultural assessment' it showed the person's religion and said they enjoyed history, music, reminiscing, photography and preferred staying indoors. Under 'Record of social, religious and cultural activities' we saw the last recorded entry was 1 October 2014. We saw there was no care plan in place to provide staff with guidance on how to support the person to receive adequate social stimulation to support their emotional or mental wellbeing.

In another person's care records there was a main file and a second file for 'daily progress notes'. In the daily notes we saw staff had concerns about the person's symptoms which said, please observe'. No further actions or recordings were made with regard to this. In the main file there was a care plan documentation checklist in place which could be ticked yes or no. This was blank with no date.

There was a document titled 'Property on admission' which did not have a name or a date of birth entered at the top and it had not been signed by the staff member who had completed the list of belongings. This meant it was not possible to determine the person the property on the list belonged to.

Each person had a number of care plans that identified their individual needs. One person had nine. Reviews of care plans had been carried out on a monthly basis however, they consisted of the same sentence 'Care plan reviewed no changes. Review in one month or when required'.

Care plans we looked at contained little evidence of contact with people's families. We found generally there was no information about people's life history. We asked the manager why people and their families had not been involved in their care plans. The manager told us they had great difficulty in getting information from people's relatives.

In one person's file it stated the person was aggressive and uncooperative when staff were delivering care. There was no information about what type of aggression the person displayed, what might trigger the behaviour or what could be done to help calm the person.

We asked staff about how people spent their days. We were told the activity worker had left and had not been replaced. A staff member said sometimes we have karaoke or bingo but there was no plan of activities at the home. One member of staff said, "People spend their days just sleeping or we'll ask them how they are. We sometimes take them out in the garden." Another member of staff said, "Nothing goes on. We try to do bits on a day to day basis but nothing is really planned. We have entertainers come in and someone who does exercises. Otherwise listening to music, watching TV and creaming legs." Someone else said, "For people with dementia, reminiscence work by chatting, postcards and books." However, we were told the activity co-ordinator took all the resources with them. The member of staff also said, "They are long days for people. Some people want to get up at 4am and are asking to go to bed at 6pm." "We have no vehicles to take people out, no money to buy things in, not enough staff to carry things out. It's not good."

We observed a member of care staff sat with a person looking through a photo album and asking them questions about each of the photographs. They also used a little wool doll to try to get the person to converse. After lunch a member of care staff brought out some large skittles and a bowling ball (all plastic) and encouraged people to take part in a competition. Some who used the service said, "We used to have an activities lady here but she left, she used to take us out. Nobody does it now." We concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints file and found there had been no recent complaints recorded. We asked people who used the service how complaints were dealt with. One person said, "If I say too much I get ignored." This led us to believe not all complaints had been recorded. We saw there were three compliments. One person had thanked staff for the care they delivered to their relative and someone else had complimented the home on their Christmas decorations.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager; however, a new manager had been appointed and had been in post since September 2014. We were told the manager was in the process of applying to become the registered manager.

At our last inspection we found there were some systems in place for assessing and monitoring the quality of the provision. However, we found many of these were not robust and did not identify or address areas requiring improvement. We therefore issued a warning notice and told the provider they should comply with our warning notice by 31 August 2014. During this inspection we found some improvements had been made and whilst systems were identifying areas for improvement these were not always acted upon.

We saw there were several audits carried out by the manager but we could not always see what action had been taken as a result of these audits. We saw a monthly 'health and safety' quality audit for October, November and December 2014. Each audit contained an action plan which was blank. We saw in each audit it said not all staff had attended 'Health and Safety' training. Each of the audits stated not all staff had received fire training in the last six months. We looked at the training matrix and found this was still the case. It stated a fire drill had not been carried out in the last three months. In October it said, 'none recorded in 3 months', in November it said, 'to be arranged' and in December it was just ticked no. There was also a question which asked 'Each wheelchair is labelled with the Residents name or a number in the case of pool chairs'. In October is said, 'not evidenced' and in November and December just ticked no. None of the areas highlighted had been added to an action plan to ensure they had been completed within the provider guidelines. The provider did not have robust systems in place for monitoring the service.

We saw the accident record for 2015 and found the record was incomplete.

We asked to see the last survey carried out to ensure people who used the service were able to give their opinion of the service. The information we were provided was from May 2013.

We concluded the provider did not have effective systems for monitoring the quality and safety of the service. This is a breach 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..

We looked at the 'quality audit of the environment' which included cleanliness, furniture, kitchen and lounge. There was an audit of the labelling of people's clothing. There was also a mattress and bed rail audit.

Staff we spoke with spoke highly of the new manager. One person said, "Under the manager (person's name) things have been sorted, it's really on the up. Gripes are sorted straight away now. I think she's a good manager. She gets stuck in." Someone else said, "It's like a little family here. The manager is brilliant. You can go to her for anything and she puts your mind at rest. She will listen to you and act immediately. She has made it much more homely." Another member of staff said, "We work as a team. They (managers) have made some improvements to the home. The windows have been changed and rooms have been decorated." "If you've had a hard day they (managers) say thank you. They're quite nice and good listeners." However, one member of staff said, "Morale's not good, we have staff meetings but they're not worthwhile, nothing changes."

A person who used the service said, "We've been very happy here. There's not too much to change. (Person's name) is a good manager."

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 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services and others were not protected against the risks associated with inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against risks associated with inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to check the quality of care provided.

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
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not protected against the risks of receiving care or treatment that was inappropriate.