Olympus Care Services Limited

Ridgeway House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

Ridgeway House is registered to provide accommodation and support for 35 older people. On the day of our visit, there were 34 people living in the home, ranging from frail elderly to people living with dementia.

The inspection was unannounced.

The service has 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 and associated Regulations about how the service is run.

People felt safe living at the home and with the staff who supported them. Staff had a basic understanding of safeguarding vulnerable people from abuse. Although they would report any concerns to their manager. There was a limited understanding of the local authority procedures.

People's safety had been compromised in a number of areas. The home had not been adequately cleaned or maintained and risks to some people had not been assessed. Care files did not consistently contain risk assessments or care plans, and medicines had not been handled safely and appropriately.

Summary of findings

Bedroom doors had been wedged open and this placed people at r risk if there was a fire in the home. In addition, on the day of our inspection there was no hot water or heating and people told us that they felt cold in the home.

There was a robust recruitment process in place. Records confirmed that staff were only employed with the home after all essential safety checks had been satisfactorily completed.

People had access to health care professionals to meet their specific needs and records confirmed this. The provider worked with other professionals to make sure people received the support they required to meet their changing needs.

People were happy with the food provided and staff knew how to support people in a way that people wanted. People at risk of not eating or drinking enough were effectively supported to have sufficient quantities of food and drink to meet their dietary needs.

Staff treated people with respect and preserved their dignity at all times. Meetings were held on a regular basis with relatives and people who used the service, to obtain their views about the home and care provided. Complaints had been dealt with in a timely manner and to people's satisfaction.

People felt that the activities available had recently improved, however, some people felt that there remained a need for more activities to be made available.

There were a variety of audits in place to assess the quality of the service that was provided. However, some of the audits had not always identified concerns or areas for improvement. For example concerns we observed as part of this inspection in relation to the safe administration of medicines, infection control and the environment had not been identified by the provider's quality assurance systems.

During this inspection we identified a number of areas where the provider was not meeting expectations and where they had breached Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People who used the service were being put at risk because the premises and equipment had not been maintained properly, cleanliness and hygiene standards had not been upheld and medicines were not managed safely. Vacant posts needed to be recruited to, to ensure consistent staffing numbers were maintained.

Staff could identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused. All the people we spoke with said they felt safe living in the home. There was a robust recruitment procedure in place to ensure people were not being cared for by unsuitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular training and were therefore not always equipped to meet people's needs.

People's care and support was not always planned and delivered in a way that consistently ensured people's health and well-being.

People had a balanced diet and were supported to take adequate nutrition and hydration.

The requirements of the Deprivation of Liberty Safeguards were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt that staff were kind and caring, treated them with dignity and respected their choices.

Care records lacked information about people's likes, dislikes and preferences. Some entries in the care plans lacked detail, and had not been written in a way that promoted individualised care.

Staff supported people to be as independent as possible and we saw staff giving people time to respond.

Is the service responsive?

The service was not always responsive.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who used the service.

Summary of findings

Improvements were needed to make sure people had opportunities to take part in social activities.

Meetings were held with relatives and people who used the service to obtain their views about the service.

People told us staff listened to any concerns they raised, however, there was no complaints procedure visable or accessible to people who use the service.

Is the service well-led?

The service was not always well led.

The manager had been in post since 14 July 2014 and people were positive about the changes the manager had made.

Staff felt supported and listened to by the new manager and felt able to raise any concerns or questions they had about the service.

The provider's quality assurance processes required some improvement in relation to records, medication, infection control and the environment.

Ridgeway 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 checked 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 04 November 2014 and was unannounced which meant the provider and staff did not know we were coming. The visit was undertaken by two inspectors.

Prior to this inspection we reviewed historical data we held about safeguarding, statutory notifications and contacted the local authority for their feedback on the service. We saw that the Care Quality Commission had received concerns in relation to insufficient staffing numbers, a lack of hot water and inadequate cleaning procedures of the environment.

We used a number of different methods to help us understand the experiences of people living in the service. We observed how the staff interacted with the people who used the service. We observed how people were supported during their breakfast, lunch and evening meal.

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

We spoke with eight people who used the service, three relatives of people using the service and interviewed the registered manager, a senior care worker, five care workers and three ancillary staff.

We looked at eight people's care records to identify if the care they were receiving reflected their identified needs. We did this by speaking with the person, the staff that cared for them and by looking at other records relating to the management of the home. We looked at five sets of recruitment files and further records relating to the management of the service including quality audits.

Inadequate

Is the service safe?

Our findings

People we spoke with had no concerns about the medicines they received. One person said, “They know what they’re doing. I have no cause to worry.” Relatives told us they had no worries that their family members were not receiving their medicines as prescribed.

We examined the procedures for the safe administration and storage of controlled medicines. The storage facilities for controlled medicines were observed to be in line with legal requirements.

We found that people were at risk of not receiving the correct medication because medicines had not always been recorded accurately. We found that the service was using two different types of Medication Administration Records (MAR) charts. One was provided by the pharmacist and the other was supplied by the provider. Each MAR chart used different codes for when medicines had not been administered. This had led to some confusion and we saw the wrong codes recorded on the MAR charts. We noted that one person was prescribed a controlled drug to be taken in the morning. The MAR chart for this person recorded a code as 'not required' on the day of our inspection. However, we were informed that the person administering the drug had entered the wrong code and they should have recorded a code for 'refused' because the person had refused to take their medicine that morning.

We saw a large number of hand written entries on MAR charts which were not dated or signed by two staff. In addition to this we were unable to find any specific guidance for medicines that were to be given ‘as needed’. When people were prescribed medicines in variable doses, for example, ‘one or two tablets’, the actual quantity given was not recorded and this could result in people receiving too much or too little medication.

We saw that staff completed monthly medication audits which showed that medicine administration was low risk within the service. However, none of the issues we identified were highlighted as part of this process. This meant people were at risk because systems to identify risks associated with the unsafe management of medicines were not identified and acted upon.

We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach 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.

Prior to our inspection we received concerns about inadequate cleaning procedures at the home. Overall people told us they were happy with their rooms and the cleanliness of the home. However one person said, “Sometimes people leave the toilet dirty.” We observed this in one toilet area of the home. Relatives were happy about standards of cleanliness in the home. One person said, “My [relative’s] room is clean and tidy and no odour. Absolutely not.”

We spoke with one of the housekeeping staff who said they were working on their own for the week of our visit and had to prioritise their work. They would not be able to hoover all areas of the home that day. However by the end of the week all areas would have been hoovered. They said, “It can be hard work.”

We observed that some parts of the home were not clean and we noticed an odour in some areas. For example, we noted that carpets in some bedrooms and some communal areas were dirty and stained. We spoke with the registered manager who said that there were two housekeeping staff, however they were in the process of recruiting for a third housekeeping post.

We asked to look at the cleaning schedules for the home and were provided with a list of tasks undertaken by the night staff. This included some cleaning of toilets and floors. However, there were no cleaning schedules in place for housekeeping staff. They spoke to us about their daily cleaning routines. They said that deep cleaning, such as carpet shampooing, was difficult to undertake due to a lack of housekeeping staff. We saw that the cleanliness of the home had been raised as a concern at the relatives meeting in October 2014. Following the meeting we saw that the carpets had been shampooed.

We found that people who required a hoist for moving and handling did not have their own individual slings. Staff we spoke with said that slings were not always washed between each person using them. This was putting people who used the service, staff and other people at significant risk of acquiring or transferring infections.

We found that the registered person had not protected people against the risk of, preventing, detecting and

Is the service safe?

controlling the spread of infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we observed seven bedroom doors wedged open with door wedges, bedroom furniture and a walking frame. These were doors with a self closing mechanism which enables the door to close when the fire alarm is raised. Wedging the fire doors open meant that people may be put at risk if there was a fire in the home. We raised this with the registered manager who said people were wedging their doors open because some automatic door closures were not working. She said this had been an on-going problem since she took up post as manager in July 2014. The registered manager had taken action to have these repaired on numerous occasions. At the time of our inspection there were still a number of automatic door closures that were still broken and doors continued to be wedged open.

Prior to our inspection we received concerns that there was no hot water in people's bedrooms. On the day of our visit we found there was no hot water available and the heating was not working. People were wearing coats and had blankets over their legs. This meant that staff had to boil kettles to provide hot water to wash people. This was resolved by an engineer later in the morning. The manager told us this had been a regular problem over the last four weeks and we saw that engineers had been called out on four occasions in one month. We were unable to find any contingency plans in place to respond to this untoward event, such as the use of mobile heaters. This meant that people were not being protected by a safe and well maintained environment.

Overall we found that the environment was not being adequately maintained to ensure people's safety.

We found that the registered person had not protected people against the risk of unsafe premises. This was in breach 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 told us they felt safe living at Ridgeway House and with the staff who cared for them. One person said, "They look after me and make sure I'm okay. I couldn't be in safer hands." Another person told us, "I feel safe here. They might be rushed off their feet but they always make sure they do their best for us." Everybody we spoke with said they would speak to staff if they were worried about anything and told us that they had no concerns about the care they received from staff.

Two relatives we spoke with also said they were not concerned about their family member's safety at the home. One relative told us, "Yes my [relative] is safe. They look after her alright." Another relative said, "My [relative] feels safe. I think the current manager will keep safety high."

We spoke with five staff about how they would raise concerns about risks to people and poor practice in the service. We found that three staff had a basic understanding of safeguarding people from abuse and stated they would report concerns to their manager and could identify some forms of abuse. Two staff said they had not received safeguarding training with the organisation and another staff member told us they had received training from their previous employer. This person had been employed with the provider for six months. Any concerns about the safety or welfare of a person had been reported to the registered manager who investigated the concerns and reported them to the local authority's safeguarding team as required. This meant that staff would report any concerns they had about care practices should they arise.

We saw evidence that the registered manager had notified the local authority, and the Care Quality Commission of safeguarding incidents.

Staff were knowledgeable about people and were able to meet their needs. However, records demonstrated that risks to people's safety had not always been assessed for people using the service. We saw three files for people either on respite care or new to the service that did not contain any risk assessments or care plans. We found that the risks of falling out of bed had not been assessed for one of these people. We joined the staff morning hand over of information and found that they had fallen out of bed during the night. The remaining five files we looked at included risk assessments associated with malnutrition, pressure damage and falls. We noted that three of these had not been reviewed since May 2014.

Three people we spoke with told us that the staff tried their best but were at times very busy. One person said, "They

Inadequate

Is the service safe?

could do with more staff. They can't always cope with everything that goes on." We spoke with the registered manager who told us that the service was in the process of a recruitment drive. We were informed that four staff had recently been recruited to the service and that recruitment was on-going. One person using the service said, "They are often in a rush and you have to wait, but they always get to you and do what they can." A relative said, "There can be a delay after pressing the buzzer. My [relative] needs two staff and always gets them."

The staff we spoke with told us they were often rushed, especially in the evenings. Two staff said they would benefit from another staff member on each shift. One said, "It's often very busy in the evening and we don't regularly manage to get a break."

At the time of our visit the staff rota showed that there were five care workers and a senior care worker on duty in the morning and four care workers and a senior care worker on duty in the afternoon. During our inspection we saw that people were attended to in a timely manner.

Requires Improvement

Is the service effective?

Our findings

We spoke with people and relatives about whether they received the right care to meet their needs. One person said, "I get the care I need. The [staff] are always there to help me." Two relatives felt their family members were well cared for.

Staff we spoke with said there had been a big improvement since the registered manager had commenced in post. One staff said, "Everything has improved and we have training tomorrow about dementia." Another staff member said, "I know the manager has a lot of plans and it's been like a breath of fresh air. The training has improved and we feel more supported." This meant that staff felt supported to improve their professional development.

We looked at the training records for staff. There was little evidence of an effective induction for some staff. This appeared to consist of a tick list which had been completed in a day. The registered manager showed us a comprehensive induction programme which they had recently implemented and we saw this was in use by a new member of staff.

Training records showed there were gaps in staff training. For example, we saw that there were 22 care staff and 12 had completed Emergency First Aid training. However 11 of the certificates had passed their expiry date. Fire Safety Awareness training needed to be updated for 19 staff and 16 staff needed to complete or update their Manual Handling training. Therefore staff were not adequately supported to acquire and maintain the skills and knowledge to meet people's needs effectively.

Staff told us that supervisions had not always been undertaken regularly in the past but had been recommenced again by the registered manager. One staff member told us, "It's a good opportunity to air views and discuss any issues we might have." Staff we spoke with told us that this process helped them to feel positive in their work and meant that people received care and support from staff that were appropriately supervised.

Overall we found that staff were not provided with regular training to develop their skills and knowledge to enable them to perform their duties effectively.

We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach of Regulation 23 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.

During this inspection we found that people were provided with a choice of suitable and nutritious food and drink to meet their dietary needs. One person told us, "The food is very tasty. We are able to choose what we have to eat." Another person told us, "Oh yes the food is smashing." Relatives we spoke with did not raise any concerns about the food. One relative said, "I know my [relative] gets enough food but I still bring in a few tit bits."

We spoke with the chef and the assistant cook. Both staff demonstrated a good knowledge of people's likes and dislikes and said they would always prepare something different for people if they didn't like what was on the menu. For example, we saw that one person was having an omelette because they wanted something light. We also saw that a fried egg sandwich had been made for another person at their request. We observed the chef talking to people and asking if they liked the food.

We observed that portion sizes were good and people were asked if they would like some more. There was a choice of drinks available to people and we saw snacks being given to people throughout the day. Daily menus' were available on each table for people using the service. We saw that fluids were available to people throughout the day and we were told that snacks were available to people whenever they wanted it.

We saw that people were involved in making decisions about what they ate at the service and we saw that the menus had been changed to reflect what people wanted to eat. For example, we saw that changes had been made to the supper menu to include more hot food. This meant that people were able to make decisions about their food and drink.

No one who used the service was subject to the Deprivation Of Liberty Safeguards as set out in the Mental Capacity Act 2005. We saw that there was a policy and procedure in place to make sure staff were aware of the process to follow if it was felt people required this level of protection. We saw no evidence to suggest that anyone living in the home was being deprived of their liberty.

Requires Improvement

Is the service effective?

We spoke with people about whether they received the right care to meet their needs. One person said, “Things have improved lately. It’s better than it was.” They continued, “Now I'm being better looked after." A relative told us, "My [relative] was taken to the dentist when they had a problem. I don’t have to worry.”

One staff member told us, “Each person likes to have their care in a different way to suit their individual needs.” Another staff member said, "Communication about changes has improved a lot recently and this has meant we are working better as a team and more effectively.” Another staff member said that information was cascaded to staff in information handovers and through communication books. This meant that staff were being provided with up to date information about people's health care needs.

We saw that people had attended regular appointments about their health needs. Five of the care files we looked at demonstrated that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists.

Requires Improvement

Is the service caring?

Our findings

During our inspection we saw that positive relationships had developed between people who used the service and staff. People we spoke with told us they were happy at the home and that staff treated them with kindness. We spoke with a group of three people sitting together who said, "It's nice here. They look after you."

A relative said, "The staff know my family member well." Another relative told us, "The staff are very helpful and always welcoming. When my [relative] gets upset the staff know how to make them feel better."

Staff we spoke with demonstrated a good knowledge about people's individual needs and preferences, including an understanding of medical and nutritional needs.

We observed staff and people interacting and engaging positively with each other when staff had time. For example, one staff was painting a person's nails and we saw another staff member chatting with a person about what was in the newspaper.

We saw that people's care plans often lacked detail about them as an individual, including information about their histories and preferences.

We saw people were given time to make decisions and staff respected the choices they made, for example, one person wanted to stay in bed until late morning and staff facilitated this. We spoke with this person who said the staff had placed their bed near the window so they could see outside and watch the wildlife. They also told us, "I'm very happy and quite satisfied. Look, they have even made me a fried egg sandwich for my breakfast." People told us they were able to make choices about what time they got up, when they went to bed and how they spent their day.

The staff we spoke with told us they felt they knew the people who lived at Ridgeway House. One staff member said, "We are always there for people to talk to and we encourage people to make choices." Another staff said, "I love working here."

The registered manager told us that no one who lived in the home currently had an advocate. They also told us they did not have any information to give to people about how they could find one. This meant people may not be aware of advocacy services which are available to them.

We found that people were treated with dignity and respect. One person told us, "The girls are so kind. They are never rude to me. We used to have some who were rude but they have gone now."

We observed that staff knocked on the toilet, bedroom and bathroom doors before entering the rooms. They said they always kept bedroom doors closed when people were being supported with personal care. A relative said, "There is dignity and respect now that some staff have left. It's much better and there have been some changes which have been welcomed."

Throughout the day we observed that staff spoke politely with people and saw that people received their mail unopened. We saw that all rooms were used for single occupancy. This meant that people were able to spend time in private if they wished to. One relative told us, "I don't see anything but dignity and respect for these people who live here."

Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. There was a family room where people could meet with their families in private. One relative commented, "There is respect and dignity now. Things have improved." Our observations confirmed that staff respected people's privacy and dignity throughout the day.

Is the service responsive?

Our findings

People told us that they received care and support that met their needs. One person told us that staff always asked them what support they needed. Throughout the day staff responded to people's need for support in a timely fashion. We observed that staff were responsive to people and were present in the communal areas, but at the same time monitoring those people who remained in their rooms

Care records did not always demonstrate that people were able to make decisions about what time they got up, went to bed and how they spent their day. There was little information in files about people's personal history, interests and hobbies. However staff we spoke with demonstrated a good knowledge about people's care needs. For example, one staff described how one person liked to get up late. They then described this persons routine for the day. This meant that although staff had a good knowledge of how people liked to receive their care, the lack of information in the care plans did not ensure that staff always had access to up to date information and did not ensure people had as much choice and control as possible.

We found that the registered person had not protected people against the risk of unsafe care and treatment by failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This was in breach of Regulation 9 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.

Some people told us they would like to see more activities in the home. A relative said, "It has improved but sometimes people sit around for most of the day with nothing to do but watch TV." We saw that numerous people were sat in front of the TV but were not engaged with the programme and several people were asleep. We did not observe people being offered a choice of activities. This meant that people who were not able to occupy themselves may receive limited social stimulation.

The registered manager and staff we spoke with said that the care staff who worked at the home were responsible for providing activities and meaningful occupation for people. There was no set activity programme in the home but we did see some activities posted on a board for visiting outside entertainers.

Meetings were held with the people using the service to discuss plans for the home and to find out their views. We saw minutes of the previous three meetings, and saw that subjects raised had included menus, activities and the cleanliness of the home. The actions taken by the provider had been recorded and showed that people were being listened to. One relative told us, "The new manager has organised meetings and we have been able to talk about things we are not happy with."

All the people we spoke with told us that they would talk to staff or the manager if they had any concerns. A relative told us that they had raised a concern and the registered manager has taken their complaint seriously and was addressing the issues raised as part of the complaint.

The service did not have any information displayed in the home to guide people with how to make a complaint. This meant that some people may not be supported to make comments or complaints. We spoke with the registered manager about the lack of information available for people using the service about how to make a complaint. The registered manager said they would raise this at the next residents and relatives meetings.

We looked at the complaints log for the service and found that complaints had been dealt with by the present registered manager appropriately and swiftly.

People told us that their families were able to visit anytime and that staff supported them to make arrangements to visit family and friends. A relative we spoke with said they visited daily and were always made to feel welcome.

Is the service well-led?

Our findings

People could not be assured that the systems in place to monitor the quality of the service and the quality of the care provided were effective.

We found that the provider had failed to identify that people's needs had not been regularly assessed and reviewed. Care records had not been audited and we saw that some people did not have risk assessments or care plans in place. Records about the care, treatment and support of people who used the service were not always updated as soon as practical. This meant that staff may not be provided with up to date information about people's needs, preferences and wishes.

We saw that staff undertook internal audits on infection control, medicines and care plans. We found that these had not picked up the issues and causes for concern that we found in each of these areas. For example, we identified some medicine omissions that had not been identified by the service's own audit system. Therefore, medical advice had not been sought for people from the appropriate healthcare professional and the incidents had not been investigated by the service to minimise any reoccurrence.

We found that essential training for staff was not up to date and there were significant gaps in staff training. The provider had failed to identify or made suitable arrangements to ensure staff were appropriately supported to deliver care and treatment to an appropriate standard by receiving the necessary training and development.

There was a lack of information in place for people in relation to accessing advocacy services or how to make a complaint. This meant that important information was not brought to the attention of people using the service in a suitable manner and format to enable them to access services or make a complaint.

Systems in place for recording accidents and incidents were not always linked to people's individual care plans. This meant there was not always a clear record of any incidents that had occurred. We were unable to find evidence that the service undertakes an analysis of incidents and accidents to identify any patterns and take the appropriate actions. This does not ensure people are protected against the risks or unsafe care.

We found that the registered person had not protected people against the risks of inappropriate or unsafe care and treatment. This was in 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.

There was a registered manager in post and they were supported by other senior staff. People told us they knew who the manager was and felt comfortable talking to them. One person told us, "She has made some changes which have been good." A relative said, "I'm impressed so far. She has made some improvements which have been good for the home."

Staff told us that they felt supported and understood their role and responsibilities. One staff member told us, "The new manager has made a good start. She listens and takes actions and has made lots of positive changes since she started." Staff told us that the registered manager had an 'Open Door Policy' and they could talk to her at any time. We saw that staff received one to one supervisions and also had staff meetings to discuss matters that affected the running of the home, being able to contribute ideas and ways to improve and develop.

There were open and transparent methods of communication within the home. In addition to day to day contact with people who lived at the home the manager held regular meetings for people and for staff. One person using the service told us, "I have joined in some meetings where we can say what we want. It's good because they listen. They changed the menus and they have been much better." One relative said, "I'm always made welcome and they keep me up to date with anything that is going on."

Staff told us meetings at the home were an opportunity to share information and ideas. One staff member told us, "The manager is available and has made a good first impression." Another staff member commented, "Everyone is now working much better as a team."

We found that the manager was meeting the requirements of their registration and had submitted notifications as required to the Quality Commission. A notification is information about important events which the service is required to send us by law in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not protected people against the risk of unsafe care and treatment that included the unsafe management of medicines, inadequate systems in place to protect people against the risk of the risk of, preventing, detecting and controlling the spread of infections and by failing ensure persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not protected people against the risk of unsafe premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected people against the risk of unsafe care and treatment by failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user and systems in place to monitor the quality of the service and the care provided were not effective.

This section is primarily information for the provider

Enforcement actions

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