

Franciscan Missionary Sisters

St Josephs Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Good 
Is the service caring?	Good 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Good 

Summary of findings

Overall summary

The inspection took place on 7 and 9 June 2016 and was an unannounced inspection.

St Josephs Nursing Home provides accommodation and nursing care for up to 24 older people. The home is built over two floors and shares a chapel with the adjacent Convent. The service was tailored for, but not limited to, people from the Roman Catholic Church. At the time of our visit there were 24 people living at the home, including three people who were visiting for respite care.

There was a calm and peaceful atmosphere at the service. Many people told us that they had chosen the home for its spiritual tradition and that they enjoyed attending daily Mass in the chapel, or watching it on the internal television channel. Relatives spoke positively about the service and the care provided.

At our last inspection, in December 2014, we asked the provider to take action to ensure that they were working within the principles of the Mental Capacity Act 2005 and to ensure that the Commission was notified of specified incidents as required by law. The provider and former registered manager had taken action to address these concerns. At this visit, we found that these requirements had been met.

The service did not have a registered manager. A new manager had been appointed in February 2016 and was due to begin the process of registering with us. 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 spoke highly of the care that they received and told us that the staff were very kind. Some people, however, told us that they felt bored and that they wished for more social activity. They told us that staff were busy and had little time to chat. Staff told us, however, that most people were happy to attend Mass daily and to rest after lunch. We found that the provider had not asked people for their views and feedback on the service, or for ideas to improve their experience, since 2014.

Medicines were not managed safely. We found concerns with the storage, recording and disposal of medicines.

People felt safe at the home. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

People told us that staff treated them with respect. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

There were enough staff to keep people safe. People told us that they were not rushed and that they received a high standard of care. Staff had received training and felt supported by the management, including through supervision and appraisal. Staff monitored people's health and took prompt action to address any concerns. People had access to healthcare professionals and appropriate referrals were made for guidance or additional support.

People enjoyed the food and were offered a choice of meals. Staff were attentive to people's needs and supported those who required assistance to eat or drink. People's weight was monitored and prompt action taken if any concerns were identified.

The new manager was active in monitoring the care that people received and was developing the system used to audit the service. People, their relatives and staff felt confident to raise issues or concerns with the manager. Where concerns had been identified, actions were recorded and addressed.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not safe.

Medicines were not managed properly or safely.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

Is the service effective?

Good 

The service was effective.

Staff had received training to carry out their roles and they felt supported.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good 

The service was caring.

People received care from regular staff who knew them well and cared about them.

People felt involved in making decisions relating to their care and were encouraged to maintain their skills and mobility.

People were treated with dignity and respect.

Is the service responsive?

The service not always responsive.

People had not been asked for their views or experiences of the service. Some people were unhappy with the activity provision and told us that staff rarely had time to stop and chat.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

People's care was planned and monitored to promote good health.

Requires Improvement ●

Is the service well-led?

The service was well-led.

People and staff felt able to share ideas or concerns with the management.

The new manager was approachable and proactive.

The new manager was assessing the service to monitor the delivery of care that people received and to make improvements.

Good ●

St Josephs Nursing 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 7 and 9 June 2016 and was unannounced.

One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed three previous inspection reports and notifications received from the former registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, their relatives and staff. 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. We looked at care records for six people, medication administration records (MAR), monitoring records for food, fluid and people's weights, six staff files, staff training and supervision records, staff rotas, quality feedback surveys, accident and incident records, staff handover records, complaints, audits, and minutes of meetings.

During our inspection, we spoke with seven people using the service, four relatives, the manager, the deputy manager, three registered nurses, three care assistants, the housekeeper and two of the chefs. We also met with a social worker who was visiting. Following the inspection, we contacted other professionals to ask for their views and experiences. These included an admission avoidance matron and a manicurist who had involvement with the service. They consented to share their views in this report.

Is the service safe?

Our findings

Medicines were not managed safely. We found some medicines had not been stored appropriately, that there were gaps in recording and that medicines had not been disposed of in a timely way.

We checked the medicines trolley and found three boxed medicines which had passed their expiry date. One of the medicines being administered had expired more than six months earlier, in November 2015. This medicine was immediately removed from the trolley and replaced. Liquid medicines in the trolley had not always been marked with the date they were opened. This is important because most manufacturers stipulate the length of time a medicine remains effective after opening. Medicines that needed to be kept cool were stored in a fridge. Staff should monitor and record the temperature of the fridge daily to ensure that these medicines are stored within the correct temperature range. The last recorded check on the fridge temperature was three weeks earlier, on 16 May 2016. Staff had not ensured that medicine was stored in line with the manufacturers' guidance so that it remained effective and safe to use.

The records of medicines administered contained gaps. In one person's record for the first six days of June, there were three gaps. Staff did not maintain records of when prescribed barrier creams were administered. The manager told us, "We trust staff to do it. Everyone has their bespoke routine. It isn't documented". This meant that we could not be sure people had received their medicines as prescribed. Some medicines require a check on the person's heart rate prior to administration. In three out of four records that we checked, there were gaps in the pulse recording. This meant that staff could not demonstrate that the medicine had been given safely.

Medicines that were prescribed on as 'as required' (PRN) basis were documented in the Medication Administration Records (MAR) and the dose given was clearly recorded. We found, however, that limited guidance on the administration of PRN medicines was available for staff. Some PRN medicines did not include detailed instructions with the prescription and nurses told us that they administered these medicines on their own judgement. We reviewed the records for one person who was prescribed a laxative 'as needed'. There was no further guidance for staff on when the laxative should be given, for example after a certain number of days without a bowel movement. The bowel monitoring records for this person showed periods of time where there was no bowel movement recorded, most recently between 21 May and 6 June 2016. The MAR chart showed that the laxative was last given in April 2016. The lack of additional guidance and monitoring could mean that people did not receive safe treatment and that there was an inconsistent approach to administering PRN medicines.

Medicines were not disposed of promptly. We found stock of medicines for one person who had passed away in January 2016. The provider's policy stated, 'It is unacceptable and unsafe to hold excess stocks of drugs or dressings'. We spoke with two nurses about the disposal of medicines. They were not able to demonstrate that a safe procedure for the disposal of medicine was in place. For example, one nurse told us that if a person spat out a tablet they would place it in the sharps bin (used for the safe disposal of syringes). They told us that this would not need to be recorded. Surplus, unwanted or expired medicines should not be stored at the service and the disposal of all medicines should be clearly documented.

Medicines were not managed properly or safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Information on how to raise a concern was displayed in the home. Staff told us that they felt able to approach the manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling or a risk of developing pressure areas, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and for staff on the support that people required. In the guidance on how to move people safely, the equipment to use was clearly documented. Preventative measures were used to reduce the risk of people developing pressure areas. These included the use of pressure relieving equipment such as mattresses and cushions and regular support to change the person's position. Where people required support to manage specific health needs this was set out in a separate care plan. For example, people who were diabetic had a diabetes care plan which detailed the target blood sugar range and the frequency of blood sugar monitoring required.

Each person had a personal evacuation plan in place which described the support they would require from staff in an emergency to leave the premises. The Fire and Rescue service had visited the home in October 2015 to review fire safety and had not identified any areas of concern. The service had a business continuity plan in place to describe the action staff should take in a range of scenarios, including a utilities failure or adverse weather conditions.

There were enough staff on duty to keep people safe. There was a minimum of one nurse on duty at all times, supported by care assistants and support staff. In addition the manager and deputy manager, both registered nurses, were usually available to offer additional support. Many of the staff had worked in the home for many years and there was good continuity in the staffing. One nurse told us, "We never use agency. It's a stable team". A relative said, "I like that there isn't a continuous staff changeover, I liked the feel of the place". People and relatives told us that staff came quickly if they needed assistance. They told us that they received good care and that staff did not rush them. While the staffing level enabled staff to meet people's physical needs, they had limited time to chat or offer social stimulation. You can read more about this in the Responsive section of this report.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. The deputy manager maintained a record of each nurse's registration with their professional body to ensure that they were safe to practice. These measures helped to ensure that staff were safe to work with adults at risk.

Is the service effective?

Our findings

People spoke highly of the staff who supported them. One person told us, "They're very good". A relative said, "They look after Mum very well". A manicurist who visited the service fortnightly said, "They give good quality care. I do see their attentiveness".

Staff had confidence in their skills and abilities. New staff completed a period of induction which included training courses and time shadowing experienced staff. Staff told us that the length of the shadowing period depended on the confidence and skills of the new staff member. New staff told us that they had felt ready to start working independently. One said, "Everyone is so friendly here, you're not thrown in at the deep end". The provider had recently introduced the Care Certificate, which is a nationally recognised qualification. The competency of new staff was also assessed during their supervision. This included an observation of their skills in supporting a person to dress and undress, mobilise and to move using a hoist. We saw that any areas for improvement of further training were documented.

Ongoing training was organised through an external training company. Staff completed workbooks and were required to sit a knowledge check which was sent off to be marked. Courses included safeguarding, moving and handling, first aid, infection control, health and safety, managing behaviour that challenges, diabetes care, the Mental Capacity Act 2005 and stroke awareness. One staff member told us, "The training booklets are really good. I've just done stroke awareness; that was really interesting". Practical moving and handling training was delivered in house by one of the nurses who had been trained to deliver this course. Additional training was available to staff, including support to complete diplomas in health and social care. One nurse told us that they had recently received training in PEG feeding (a tube placed directly into the stomach through which fluid and nutritional fluid can be delivered) and that they were booked to attend a wound care course. Another nurse had attended infection control champion training with the local authority and a third was due to attend a refresher course in catheterisation.

Staff told us they felt supported. One staff member said, "We can always ask if anything is worrying us. Everyone is very open here". Another told us, "The nurses are so easy to talk to". Staff told us that they received supervision with a named nurse. In the staff folders that we looked at we found evidence of this, although a record detailing past supervisions and appraisals for all staff had not been maintained. The new manager had revised the supervision list and shared this with staff. We saw that supervisions included a discussion of the staff member's strengths and weaknesses, their training needs/wishes, a record of any issues discussed and any agreed actions. Staff told us that the meetings were useful. One said, "It's good because you can talk about where you want to go".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, one application had been made to deprive a person of their liberty but this had not yet been assessed by the local team.

At our last inspection, in December 2014, we found the provider was unable to demonstrate that they had followed the principles of the MCA and its associated Code of Practice. We set a requirement and asked the provider to take action. At this inspection we found that staff had been trained in the MCA. The manager and staff were able to explain how they applied the principles of the MCA in their daily work and ensured that people's rights were protected. The requirement was met.

At the time of our inspection, most people were able to make decisions relating to their care and treatment. People had been involved in determining the support that they received and had often signed their care plans to demonstrate consent. People had been asked to document their future wishes in an advanced care plan. This would help to ensure that their preferences on key decisions such as where they would wish to be cared for at the end of their life were respected in the event that they did not have capacity to make such decisions in future. Where people had appointed representatives to act on their behalf, this was clearly documented. One person's appointed power of attorney for health and welfare had been involved in the decision to use bed rails and a lap strap to reduce the risk of the person falling from bed or their wheelchair. This was documented in the person's care plan.

People told us that they enjoyed the food at the service. One said, "The food is very good". Another told us that they had just enjoyed a, "Nice lunch". The kitchen provided meals for the service and the adjacent Convent. A menu was displayed outside the dining room offering a choice of main meals. People were provided with the menu in advance in order to make their choices, sometimes with support of relatives or staff. This was then communicated to the kitchen. One staff member told us, "They can come off the menu if they don't fancy it" and added, "They often change their mind any way". On the day we visited the eight people eating in the dining room all opted for the Shepherd's pie with vegetables and gravy but one person did have an alternative dessert. Other preferences, such as a glass of red wine with lunch, were also accommodated.

Staff were aware of people's particular dietary needs and preferences and took this into account when placing the meal orders with the kitchen. We saw that the order included requests for soft meals or to mince the steak. Each floor of the service had a kitchenette which care staff used to prepare drinks and snacks for people. People were weighed monthly and staff maintained a record in the care plans. Any weight loss or gain was noted and action taken if necessary. Staff were maintaining a food chart for one person who had lost weight so that they could monitor what and how much they had eaten. Another person had put on weight after involvement of the GP and dietician. As we visited people in their rooms we observed that they had drinks to hand. Any particular directions, such as to thicken fluids to reduce the risk of choking were recorded in the care plans and observed by staff.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. People told us that they were able to see the GP who visited the service each week. We noted that professionals including the tissue viability nurse (TVN), dietician and optician had been contacted as required. At the time of our inspection an admission avoidance matron was supporting the nurses to manage the health need of one person who had moved to the service as an emergency admission. This was because the nurses who worked at the service required a training refresher in this area, which had since been arranged. Professionals that we spoke with told us that staff made appropriate referrals and took their recommendations on board.

Is the service caring?

Our findings

People enjoyed good relationships with the staff who supported them. One person told us, "They're kind as anything". Another said, "The staff are nice to me, we do get on very well". Relatives were equally complimentary. One told us, "They're very kind and very caring. It's as lovely as can be. They take a genuine interest". Another relative had shared feedback about the home on a review website. We read, 'The staff were caring, sensitive, encouraging, humorous and thoroughly professional. My mum could not have been in a better place'. Staff were able to tell us about people and their backgrounds. One staff member said, "I enjoy the residents, you get to know them very well. You get a good bond with them". Some people also spoke of having formed good relationships with others who lived at the service. They told us that they would call in and see them in their rooms from time to time.

People told us that staff knew them well and understood how they liked to be supported. They felt involved in planning their care and told us that staff took time with them as they were supported to wash and dress. In one person's bedroom we saw that their drawers and cupboards had been labelled with what was inside. This helped the person to retain their independence in selecting what they would like to wear. When a person was considering moving to the service, they were encouraged to visit. We heard the manager speaking with relatives and arranging a time for the person to come and see for themselves. The manager told us, "We show them round, show the chapel and talk about the day to day. When they're admitted we go through meals etc. We adapt to each person".

People were supported to be as independent as they were able. Care plans included guidance for staff on where people needed assistance. For example we read, 'Unable to wash or dry her back'. A staff member told us, "Some have their routines they do themselves". Staff spoke proudly about how they had supported people to improve their mobility and regain skills. One said, "After discharge (from hospital) we've managed to get some walking again. We start by getting them out of bed and to the chair and then to stand. It's gradual, they build it up". Another staff member described how they had supported one person to have a bath after a period of ill-health when they had been nursed in bed. They told us that they had reassessed the person, ensured additional staff were available to support and made sure that the person was alert. They told us that the person had really enjoyed their bath.

People felt respected and told us that staff were mindful of their privacy. Staff were discreet when discussing people's care. At lunchtime the nurse served two people with their "Cocktail". One person told us afterwards that this cocktail was actually the laxative they took on a daily basis. We observed that staff were polite and that they addressed people by their preferred name and or title.

Is the service responsive?

Our findings

People had not been asked for their views on how the home was run and for their feedback on changes that would improve their experience. The last time people were surveyed for their feedback was in August 2014 through a questionnaire about their satisfaction with the service and another about activities. Since that time new people had moved to the service. We found that some people were unhappy with the opportunities for social stimulation and engagement. The provider was unable to demonstrate that they had used people's feedback to evaluate and improve the service.

Many people told us that they had chosen the home for spiritual reasons and because there was a daily Mass that they could attend or watch via an internal television channel. One person said, "I'm happy to be here because of the spiritual background". A relative told us, "Mum enjoys going to Mass every day". They told us, however, that besides Mass, there was limited activity and that staff had little time to sit and chat with them.

We observed that staff were busy meeting people's physical needs and that, while people were not rushed when receiving care, most interactions were task based. Although people told us that staff responded quickly if they needed assistance, some told us that they felt bored. One person told us, "They're always busy. They don't have time to sit and chat much". Another said, "I get bored stiff sometimes just sitting. If I have a visitor it's nice, otherwise you've got to find something to do or it's boring". A third told us, "There is nothing to do. They care for you but they never have time to sit and talk. I do need the care but I also need the companionship". A fourth said, "The staff are caring, they just don't have the time".

Although people's preferences and interests had been recorded when they moved to the home, they told us that they had not been asked about activities. One person said, "I've never been asked, but they wouldn't have time to do it anyway". Staff told us that there was a limited appetite for activity and that most people were content to attend Mass and rest after lunch. One staff member said, "On the whole, what they're here for is the chapel. They like the quietness of the place". Another told us, "We tried activities but they actually don't want to do it. A lot stay in their rooms". At the time of the last survey, in August 2014, people had expressed an interest in activities, including visits from a PAT dog, tea and chat afternoons and minibus outings. Besides the daily Mass, a limited activity programme was in place. This included a monthly concert run by staff, visits from the resident priest and fortnightly visits from a PAT (Pets as Therapy) dog. Staff told us that there had not been any minibus outings since our last visit in December 2014. We found that the service had not sought feedback from people and had not evaluated the service to ensure that people's emotional and social needs were catered for.

The provider had not sought feedback from people to evaluate and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the feedback we received from people regarding activities with the manager. She told us that the questionnaires would be repeated in the coming months and shared her intention to allocate staff time to activities. Following our visit, she wrote to us saying, 'We will initiate within the next few weeks a small

activity programme and ask one of the current care staff if they would like to take on the role of activity co-ordinator.'

The manager listened to concerns and was taking action to make improvements. Some people told us that the daily routine in the home was quite rigid. One person said, "There's always time for this and that, and time for everything". Another told us, "I have to wait here until they come and get me. They'll get me up to a time. They keep it in order". The manager had taken steps to address this and to promote choice for people. In the minutes of a staff meeting we read, 'It is difficult to have a set routine as this is the residents' home and things can change daily. If they want a 'lie in' then it should be allowed'. At the time of our visit, staff told us of two people who enjoyed a 'duvet day' from time to time, where they opted to rest in bed during the day. Another person told us, "You can have a bath or a shower everyday which is good".

People and relatives understood how to make a complaint. Information on how to complain was displayed in the entrance of the home. Most people told us that they had not had cause to complain. One said, "I haven't had any argument with anyone". A relative told us, "The staff are wonderful, I've got no complaints whatsoever". One relative who had shared concerns with the manager told us, "(Name of manager) dealt with it fantastically. I do feel that things have been better. She took it seriously; I thought it was all very well resolved".

Each person had a care plan describing how staff should meet their needs in areas such as personal care, eating and drinking, sleeping and continence. The care plans included people's preferences, such as having their hair washed over the sink rather than in the bath and wearing a dress rather than skirts or trousers. People's health and the effectiveness of the care provided was monitored. For example, output charts were maintained for people who used catheters to check that they were draining effectively and repositioning charts demonstrated regular support to reduce the risk of people developing pressure areas. The level of support each person required was reviewed monthly, or sooner if significant changes were noted. The care plans had been updated to reflect changes in people's support needs, for example one person now used a walking frame rather than a stick as this offered additional support.

Staff had responded to changes in people's needs and taken action to promote good health. Where staff had noticed changes in people's behaviour they monitored them and carried out checks, such as by testing urine to see if there was an infection. One staff member told us, "You can tell in their behaviour that they're not very well". Any change in people's skin condition was reported and prompt action taken to promote healing. When one person developed a pressure area staff had involved other professionals including the GP, dietician and tissue viability nurse (TVN). A nurse told us, "(Name of person) came in with blistered heels but they've now healed". At the start and finish of each shift, staff shared updates during a handover meeting. We saw that this included instructions to encourage fluids if a person had not been drinking well, to monitor a person after they had fallen and a reminder of any dressings that needed to be changed. This helped to ensure that staff were aware of any changes and that people received consistent and appropriate support. A manicurist who visited the service fortnightly told us, "If I am concerned about anyone, I will point it out for Sister and she'll check straight away. They're very good".

Is the service well-led?

Our findings

At our last inspection, in December 2014, we found the provider had failed to notify us of a serious injury. We set a requirement and asked the provider to take action. The former registered manager quickly sent in the missing notification and continued to notify us of incidents as required by the law. The new manager was aware of her responsibilities to notify the Commission without delay. The steps taken meant that the requirement was met.

Since our last inspection, a new manager had been appointed and started in post during February 2016. At the time of this inspection the manager had not yet started the process of registering with the Commission. The manager demonstrated an understanding of the process and we will check to see that an application is received. People spoke positively about the manager. One person told us, "She's a nice person". A staff member said, "(Name of manager) is really good. It's run really well here". Another staff member told us, "She is easy to talk to. You can say you're not happy with something". Other staff told us that she had already dealt with some problems and that they could see that she was, "Getting things done".

The manager held a nurses meeting in April 2016 and an all staff meeting was planned before the Summer. Systems were in place to ensure that staff understood their responsibilities. For nurses, these included jobs such as recording people's weight on a monthly basis, updating care plans and supervision of named care staff. Care staff responsibilities included checks that bedrooms were safe and that people had the sundries they required, tidying the wheelchair store and cleaning the meal trays. One staff member told us, "I think we work as a good team. The bosses are good. (The new manager) is finding her feet, she's a lovely lady".

The manager was working to understand the service and to assess where improvements could be made. Staff told us that the manager spent time observing how care was delivered to people. One staff member said, "(Name of manager) is everywhere, she is more engaged". The manager told us that she regularly observed staff practice in the home. She told us, "If I see a drink out of reach, I address it on the spot. I speak with the staff member and discuss the expectations. They are not just here for a job". This helped to monitor the quality and consistency of care that people received and to drive improvement.

As the manager was new in post some areas of the service had not yet been audited. We found, however that a plan was in place. For example, a nurse had been appointed as infection control champion and the manager was looking at a variety of infection control audit tools to pick one suitable for the service. A medication audit and audit of the care plans was also planned. The manager had completed a monthly review of accidents and incidents. This helped to identify any trends or patterns which could then be addressed to reduce the risk of repeat events. A two-monthly assessment of the service was also prepared for the provider. This report covered new admissions, equipment that had been serviced and any staff changes. Staff told us that the provider visited the service on a regular basis.

The manager took prompt action to address known concerns. Following this inspection where we identified concerns over how medicines were managed, she wrote to us confirming that checks on the medicine trolley would be formally recorded. We read, 'In light of the issues highlighted during your visit, we are now

implementing a checklist that will be signed as appropriate'. Actions from earlier audits, such as the health and safety audit completed in July 2015 and external checks on the premises and equipment had been logged and were being addressed. For example, new hoist slings had been ordered to replace two that were worn.

The provider had displayed the rating received following our last inspection in the main entrance to the home. We noted that the rating had not been displayed on the provider website. This was addressed by the manager who took action to ensure that the rating was appropriately displayed on the website.

The service was rooted in the Catholic tradition and there was a strong spiritual ethos. People and relatives spoke of the calm and peaceful atmosphere. They told us that they were free to express other faiths or none. One person told us, "There's no pressure to become a Catholic". Another said, "It's quite a happy place. It's a good home". Relatives spoke highly of the service. One told us, "We think it is really, really good". Another said, "I trust what they are doing here". Staff felt able to openly share ideas or express any concerns. One staff member said, "Management are so approachable. I feel so comfortable here. It's like one big family". Another told us, "If you've got problems she (the manager) will try to help".

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
Treatment of disease, disorder or injury	Medicines were not managed properly or safely. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not sought feedback from people for the purposes on continually evaluating and improving the service. Regulation 17 (2)(e)