Folkestone Nursing Home Ltd

Folkestone 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the last inspection of Folkestone Nursing Home in May 2015 we found one breach of legal requirement because care was not always being delivered in line with people's assessed needs. During this inspection we found that improvements had been made. We also found some issues of concern at our previous inspection in relation to the management of medicines and we made a recommendation for them to introduce systems to support the safe administration of medicines. This issue had not been sufficiently addressed by the time of this inspection.

The service is registered to provide accommodation and support with nursing and personal care to a maximum of 43 adults. 40 people were using the service at the time of our inspection. The service had a registered manager in place. 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.

Medicines were not always administered in a safe manner. Staff did not always receive up to date training in relevant topics to support them in their role. Quality assurance and monitoring systems were not always effective.

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

Systems were in place relating to safeguarding people that used the service. There were enough staff working at the service to meet people's needs in a safe manner. Checks were carried out on new staff before they began working at the service. Risk assessments were in place which included information about how to mitigate any risks people faced.

The service operated within the Mental Capacity Act 2005 and people were supported to make choices where they had capacity to do so. This included choices about what people ate and drank and people told us they were happy with the food provided. However, not everyone received their meal while it was still hot. People had access to health care services as required.

People and relatives told us staff behaved in a caring manner and that people were treated with respect. Staff understood how to promote peoples dignity.

People were involved in developing their care plans which were regularly reviewed. People had access to various activities. People knew how to make a complaint.

People that used the service and staff told us they felt the management team was open and supportive. The service had various quality assurance systems in place, some of which included seeking the views of people

that used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Medicines were not always managed in a safe manner.

Systems were in place to protect people from the risk of abuse. Staff knew their responsibilities with regard to safeguarding.

Risk assessments were in place which set out how to support people in a safe manner. Staff told us the service did not use physical restraint or intervention when working with people who exhibited behaviours that challenged the service.

There were enough staff working at the service and checks were carried out on prospective staff, including criminal record checks.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always receive up to date training in mandatory subjects.

People were supported to make choices and where they lacked capacity the home operated within the Mental Capacity Act 2005.

People were provided with sufficient amounts of food and were able to choose what they ate and drank. However, not everyone received their meal while it was still hot.

People had access to health care professionals as required.

Is the service caring?

Good

The service was caring. People told us they were treated in a caring way by staff. We observed staff interacting with people in a polite and friendly manner

Staff had a good understanding of how to promote people's choice, privacy and independence.

Is the service responsive?

Good

The service was responsive. Care plans were in place which were

subject to regular review. These set out how to meet people's needs in a personalised manner. People had access to various activities.

The service had a complaints procedure in place and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service had various quality assurance systems in place, some of which included seeking the views of people that used the service. However, these were not always effective. The quality assurance processes failed to identify some issues with medicines and staff training.

There was a registered manager in place and people and staff told us they found management to be helpful and supportive.

Folkestone 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 over two days on the 7 and 10 June 2016 and was unannounced. The inspection team consisted of one CQC inspector and one CQC pharmacy inspector, a specialist advisor and an expert by experience. 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 we reviewed the information we already held about this service. This included details of its registration, previous inspection reports, feedback from people and notifications the provider had sent us. We spoke with the local authority that had responsibility for commissioning care from the service to gain their views.

During the inspection we spoke with eight people that used the service and three relatives. We observed how staff interacted with people. We spoke with 13 staff. This included the registered manager, the administrator, the chef, the activities coordinator, a registered nurse, three team leaders and five care assistants. We spoke with two health care professionals who were visiting the service during the course of our inspection. We reviewed six sets of records relating to people's care including risk assessments and care plans. We looked at medicine practices and records. We looked at six sets of staff recruitment and supervision records and training records for all staff working at the service. Other records we saw included minutes of meetings, audits, surveys and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2015, some medicines were not managed safely. We discussed these issues with the manager during the inspection. They told us that they were new in post at that time and had not yet implemented a system for auditing medicines. They wrote to us on 18 May 2015 to confirm that they had taken steps to address all the issues of concern we raised with regard to medicines. Although the issues we observed were rectified promptly, we made a recommendation that the service introduce robust systems for managing and monitoring the safe management of medicines.

At this inspection, we found that robust systems were still not in place to monitor whether medicines were being managed safely.

We noted an issue with the use of controlled drug patches prescribed for the relief of pain. There was no evidence that the site of application of the patch was rotated every week, as instructed on the manufacturer's leaflet inside the box, which may have placed people at risk of avoidable side effects.

We checked a sample of records for medicines prescribed to be administered 'as required' (or PRN) for conditions such as pain and insomnia. There was a protocol in place for a sleeping tablet, providing staff with information on how to administer this medicine, however the instructions were incorrect. The protocol instructed staff to administer two tablets at night. This did not match the instructions on the person's medicines chart, which instructed staff to administer one tablet at night. Although the person had not received an incorrect dose, the incorrect instructions on the protocol placed this person at risk of receiving an incorrect dose.

Two people with dementia were prescribed 'when required" pain- relieving medicines. The manager told us that PRN protocols had been put in place for all PRN medicines, however there was no PRN protocol in place for one person. Therefore staff had no information on what these pain medicines had been prescribed for, whether the person was able to ask for their pain relief, or whether staff had to carry out a pain assessment to make a decision on whether to administer a dose. For another person, a pain assessment tool was available in their care records to monitor the level of their pain, however this had not been used since June 2015. The nurse told us that they assessed people's pain informally, by observations, without using pain tools, because they knew the people living at the home well, but there were occasions when staff were on duty who were less familiar with people.This placed these people at risk of not receiving their PRN pain-relief medicines correctly, consistently and when they needed them.

Safe arrangements were not in place to administer medicines covertly when people did not have capacity to consent to taking essential medicines. Authorisation was in place from the GP to administer medicines covertly, in people's best interests, however staff were crushing tablets for two people without checking with the pharmacist that this was a safe method of covert administration. For some medicines, covert administration should be carried out by placing tablets in food rather than crushing, so using an unsafe method can lead to adverse effects.

Prescribed creams were kept in people's rooms and applied by care assistants. Although there was a record in use to document when these were applied, care assistants were not provided with sufficient instructions to use these correctly, for example how often and where to apply the creams. Staff responsible for applying a prescribed cream gave us different answers when we asked what the site of application was for one person's cream. Some of the prescribed creams listed on another person's MAR were not available in their room. The manager said that these may have been discontinued by the doctor, but there was no written evidence of this. There was also an open and partly used prescribed cream dated November 2015 in this person's room which had not been prescribed for them. This placed people at risk of not receiving their prescribed creams safely.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager wrote to us on June 28th 2016 to confirm that all of these issues had been addressed.

There were also areas of safe medicines management. Medicines were stored securely and at safe temperatures in the clinical room, which was clean, spacious and well ordered. The ordering system for medicines was effective so all oral medicines were available, and the medicines charts for these oral medicines were filled in clearly, providing evidence that most of the people at the service were receiving their medicines safely.There was evidence that people's medicines were reviewed regularly by the GP and there was no overuse of sedating medicines.

People and their relatives told us they felt safe using the service. One person said, "I feel safer here than at home. I took a tumble and broke my leg." Another person said, "It is safe. To be honest I've never really thought about it. But I don't feel in trouble here." A relative said, "In my eyes it is safe and good (here)."

The service had a safeguarding adults procedure in place. This made clear their responsibility for reporting any safeguarding allegations to the relevant local authority and the Care Quality Commission. The registered manager and staff were aware of their responsibilities with regard for reporting safeguarding allegations. One staff member said, "If I see anybody being abused I have to whistle blow. That means I have to go to my manager. Then we go to CQC if the manager does not do anything." Another staff member said, "If I see anybody abused I have to complain to the manager." The service had a whistleblowing procedure in place which made clear that staff had the right to whistle blow to outside agencies such as the Care Quality Commission if appropriate.

The registered manager told us there had not been any allegations of abuse at the service since our previous inspection. They told us the service did not hold any money on behalf of people. This reduced the risk of financial abuse occurring.

Risk assessments were in place which included information about the risks people faced and what action to take to mitigate those risks. For example, the risk assessments about safe moving and handling detailed what level of staff support was required and the equipment to be used for each moving and handling task. Other risk assessments included the risks associated with pressure ulcers, falls, and malnutrition. Staff had a good understanding of how to promote people's safety in line with their assessed needs. One member of staff said, "We like our residents to be clean and comfortable, this helps us to minimise pressure areas. At the moment we do not have pressure sores or skin conditions and that is how we like it."

The registered manager told us the service did not use any form of physical intervention to restrain people,

other than the use of bedrails. Staff we spoke with confirmed they never physically restrained people. Risk assessments were in place about supporting people who exhibited behaviours that challenged the service. This was personalised around the needs of the individual person. For example, for one person the risk assessment said if the person was becoming agitated staff should seek to distract them by talking about football or films, two subjects that they had an interest in. One member of staff said, "No, we don't use it (restraint) at all. We try to calm them down by talking to them."

The service did use bedrails where a risk assessment had been carried out and it was determined there was a significant risk of the person falling out of bed. People signed to consent to the use of these, and where they lacked the capacity to consent a mental capacity assessment had been carried out which involved their family members.

Most people told us there were enough staff to meet their needs. One person said, "There are always a lot of staff around." Another person said, "I know the people [staff] here and I can get hold of them when I want." Another person said, "Staff are always around and there are buzzers everywhere to help you get hold of one. They are really good at night as well. Always someone about at night time." However, one person said, "They can do with some more staff. It doesn't really affect me but sometimes meal times can take too long."

Staff told us there were enough staff working at the service and they had enough time to carry out all their duties. One staff member said, "We have recruited new staff and I think we have a full staff team now. I think its OK (staffing levels)." Another staff member said, "At the moment there is enough staff." We observed staff were unhurried during the course of our inspection and were able to meet people's needs in a timely manner. Where people required support with using a hoist we saw two staff assisted them with this.

The service had robust staff recruitment and selection processes in place. Staff told us and records confirmed that checks were undertaken before they were able to commence working at the service. Staff had to undergo an interview to determine their suitability and checks carried out included employment references, proof of identification and criminal records checks. This helped ensure that suitable staff were recruited.

Requires Improvement

Is the service effective?

Our findings

The service had a training matrix which included details of what training each staff member had undertaken and the date it was last completed. The administrator told us they were responsible for checking when staff were next due any training. However, the matrix did not include details of the date staff were due for their next training. The registered manager told us that some training subjects were mandatory for staff, including food hygiene, moving and handling, first aid, health and safety, fire safety and safeguarding adults. They said that the expectation of the service was that staff would have refresher training in these subjects every two years. However, records showed that not all staff training was up to date. For example, 17 of 44 staff we checked had not undertaken moving and handling training in the past two years, 12 of 49 staff had not undertaken first aid training in the past two years and 19 of 49 staff had not undertaken safeguarding training in the past two years.

Lack of staff training potentially impacts on their ability to carry out their duties and means people might not receive safe care in line with their assessed needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out an induction with new staff which covered policies and procedures and safe working practices. However, new staff had not undertaken the Care Certificate. We discussed this with the registered manager who was aware of the Care Certificate and told us they intended to have all new care staff complete the Care Certificate. The Care Certificate is a training programme designed for staff that are new to working in a care setting.

Staff told us they had two days shadowing experienced staff members at the beginning of their employment. This was to provide staff with the opportunity to learn how to support individuals that used the service. One newly recruited staff member said of their induction, "I feel the initial training I am having is preparing me well for the job. I feel confident I can care for the residents and know to ask for help if there is something I am not sure of."

Staff told us and records confirmed that they had regular one to one supervision with a senior member of staff. One staff member said, "We have it every three months. In supervision he [registered manager] asks me questions, things like how do I find it, how are the floors [units of the home], do I need to tell him anything?" Another staff member said they used supervision to talk about, "How I handle the service users, how I speak with them and give them care, how I communicate with the other staff, things like that."

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).

We found that assessments had been carried out to determine if people had capacity to make decisions for themselves. Staff told us they supported people to make choices as much as possible and where people lacked capacity family members were consulted. Staff told us how they supported people to make choices. One staff member said, "We take the clothes out and show them, they will say which one they want. They have their body language, if they don't have capacity and don't want to come out of bed they might push themselves back on the bed and so you leave them where they are."

People that used the service or their relatives had signed forms to indicate they gave consent to have their photograph taken both for purposes of identification and clinical needs. This showed people were consulted and able to make choices about their care.

We found that some people that used the service were subject to a DoLS authorisation. The service had followed the proper process in obtaining these authorisations and had notified the Care Quality Commission in line with their legal responsibility to do so. Staff were knowledgeable about DoLS and the implications it had for people that used the service.

People told us they liked the food and they had choice about what they ate. People told us the food met their cultural preferences. One person said, "I'm never hungry here. They cook it like I do at home and I love the gravy." Another person said, "Food is alright. We get a couple of choices and you can ask for something else if you don't want them." Another person said, "I love the food, I really do like it. You can pick what you want. The choices are one or two things then they will make you something else if you want." A relative said, "At first [person that used the service] did not like the food, she wanted Sri Lankan food, and that was arranged."

Care plans included information about people's food likes and dislikes and records showed people were offered a choice of meals. We observed the chef asking people what they wanted for lunch during the course of the inspection and the chef told us if people did not want either of their choices on the menu they would prepare them something else, depending on what ingredients were in stock.

We observed the lunchtime period and food appeared appetizing and nutritious. People were seen to be enjoying their meals. Fresh fruit juice and drinking water was available to people throughout the course of inspection and people were offered hot drinks and snacks. Where staff support was required with eating this was done in a sensitive manner, with the staff member supporting people at a pace that suited them. People were able to eat either in communal areas or their own rooms.

Risk assessments were in place for people about malnutrition and dehydration. People were weighed monthly and where there was a concern about weight loss more often. We found the service made referrals to appropriate health care professionals regarding malnutrition and dehydration including to the dietician service.

Food was prepared in the kitchen which was located in the basement. Meals where then transferred on trolleys to the three floors people lived on. The trolleys were not heated and we noted that some of those people that were served their meal last did not receive it while it was still hot. We discussed this with the registered manager who acknowledged this was an issue. We recommend that the service take steps to ensure that all people using the service are able to receive a hot meal.

People told us and records confirmed that they had access to health care professionals, including GP's, dentists, opticians, tissue viability nurses, speech and language therapists and opticians. One person said, "The doctor comes round and you just need to go downstairs and talk to him." Relatives told us they were kept informed of their relative's health care needs. One relative said, "I get a call when she's unwell like a chesty cough or an upset tummy and asked if there was anything in particular I wanted to do."

On the day of our inspection a GP and a speech and language therapist visited the service and we spoke with both of them. They gave positive feedback about the service. They told us that staff had a good understanding of peoples health care needs and referrals were made in a timely manner. They told us that the service was good at following any guidance given to support the health and wellbeing of people. One of them added that they found the registered manager to be well organised and that them having a clinical background helped. The registered manager was a registered nurse.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the staff and the way they interacted with people. One person said, "Yes, they [staff] knock on my door and they talk to me." Another person told us, "Staff are always respectful." Another person said, "I have not needed to complain about anything. Everything here is wonderful." Another person said, "The staff are very friendly." A relative said of the staff, "They are friendly, we chat and I get all the information." The same relative told us how they supported their relative with their cultural needs, telling us, "They put the Tamil channel on in her room which we asked for."

39 of the 43 bedrooms included an ensuite toilet and hand basin which provided people with privacy. People were able to have their own telephones and we observed a person having a conversation on her mobile phone which helped to promote people's independence and privacy.

Care plans included information about people's likes and preferences in a personalised manner. For example, the care plan for one person said they liked reading newspapers and listening to music, and went on to say what papers they preferred and what music they most enjoyed. In addition, care plans included information about people's past life history, such as their previous employment, where they lived and about their family. This enabled staff to learn about individuals and improved their ability to develop good relations with people. Care plans also contained people's preferred form of address and we saw staff using these during our inspection.

Care plans included information about how to communicate with people to best facilitate their understanding and to involve them in their care. For example, the care plan for one person stated, "[Person that used the service] care team are to explain any planned interactions and gain her consent and cooperation prior to commencing. [Person that used the service] is to be provided with simple, one step instructions in order to alleviate confusion."

We observed some positive and caring interactions between staff and people that used the service. For example we saw a staff member playing with a teddy bear that belonged to a person and the person was laughing and clearly enjoying the interaction. People were seen to be relaxed and at ease in the company of staff. We saw good conversations and even though it was not always clear the person fully understood the conversation, with staff they were engaged with them.

Staff had a good understanding of how to promote people's dignity, choice and privacy. One staff member said, "As soon as you go in (to a bedroom) you have to talk to them and tell them what you are going to do. Make sure the door is closed once you start giving personal care." Another staff member said, "We have to ask them their choices, for clothes, if they want a shower." Another staff member said, "If a service user is in their room my first priority is to give them privacy and close the door. I go to the person and introduce myself and tell them what I would like to do to gain their consent. I explain the procedure to them and constantly re-assure them as I am going along."

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to their needs. One person said, "The staff here are very good. They take care of all of my needs." A relative told us how they met their relative's communication needs, telling us, "[Person that used the service] speaks Tamil and one of the carers speaks Tamil." The same relative said that they had seen improvements with their relative since they moved in to the home, telling us, "When I come she looks clean and fresh, all the itchiness is gone." Another relative told us, "I know nothing is perfect in this world but this home is good. I like visiting and always feel welcome. When I go home I feel reassured my wife is looked after." Another relative said, "There's no force used. If she doesn't want to do it, they will talk and have a discussion and if there are any problems they will talk and sort it out properly. Such a peace of mind since she's been here. They also have a care plan, which we've read through and signed and if there are any problems they can give us the care plan to read."

The registered manager told us after receiving a referral he and another member of staff met with the person and their relatives to carry out an assessment of their needs. A relative confirmed this was the case, saying, "They did it at home, [registered manager] and another staff came and assessed her." The registered manager told us the purpose of the assessment was to determine if the service was able to meet the person's needs and said on occasions they had declined to take on people as the service was not suitable for their needs. Family members were invited to visit the home to help them decide if it was a suitable placement for their relative before they moved in.

The registered manager told us that after a person moved in to the service care plans were developed within a week. These were drawn up in consultation with the person, their relatives and staff that worked with them so they were able to reflect the persons needs and wants. We found care plans were in place for people which provided information about how to meet their assessed needs. These included needs around emotional wellbeing, mobility, communication, eating, drinking and nutrition and continence promotion. We saw that care plans were being followed by staff. For example, one person required support with catheter care and we saw a clear care plan in place and records showed this was being followed.

Care plans were subject to monthly review. They were signed by the person's next of kin which showed family members had been involved in planning the care for their relative.

People told us activities were provided at the service. One person said, "I play bingo but I like to sleep a lot more. I also sometimes use the art room." The service employed an activities coordinator. We observed them during our inspection supporting people to take part in various activities, both on a group and individual basis. These activities included drawing and making greetings cards, an exercise session with ball games and playing board games with people. The activities coordinator told us that people were involved in choosing activities, saying, "I speak to them, ask what they like to do." We saw there was a weekly activities timetable which was on display at the service. Activities taking place on the day of our inspection were in line with the activities timetable. Photographs were on display in communal areas of the home showing people enjoying taking part in various activities which helped to give a homely feel to the environment.

People and their relatives were aware of how to make a complaint, telling us they would report anything to the registered manager. The service had a complaints procedure in place. This included timescales for responding to any complaints and details of who people could complain to if they were not satisfied with the response from the provider. The registered manager told us there had not been any complaints received since our previous inspection.

Requires Improvement

Is the service well-led?

Our findings

The service had various quality assurance and monitoring systems in place. However, these were not always effective. For example, although regular audits were carried out of the medicines practices and records these had failed to identify the issues of concern we found with medicine practices during our inspection. Monitoring systems had also failed to identify that not all mandatory training for staff was up to date.

The lack of effective monitoring systems potentially out people at risk of unsafe care and support and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us various audits were carried out to monitor the quality of care and support provided. Records showed that a monthly health and safety audit was carried out, which included checking the first aid boxes, food temperature records, security arrangements at the home and maintenance issues. Care plan audits took place to check care plans were complete and up to date. An audit of the infection control procedures in the home found that clinical waste was not being disposed of in a safe matter and steps were taken to address this issue.

The registered manager told us they carried out various spot checks. For example, they did unannounced spot checks during the night time. They said a spot check of the kitchen revealed the cleanliness was not of a satisfactory standard and steps were taken to address that. We found the kitchen to be clean during our inspection.

Meetings were held for people that used the service and their relatives. One relative said, "They have a meeting to tell you what's going on and ask us how we feel." Records of the most recent meetings showed discussions about menus and activities. The service had a suggestion box whereby relevant persons could make suggestions about ways to improve the service, although the registered manager told us no suggestions had yet been made through this method.

The service carried out an annual survey of people that used the service, their relatives, professionals and staff. The most recent survey was conducted in May 2016. At the time of our inspection the results had yet to be analysed but the registered manager told us they intended to analyse the results and produce an action plan to deal with any issues highlighted in the survey. We viewed some of the completed survey forms which included positive feedback. For example, one relative wrote, "Good manager – approachable. Good food, nurse very helpful." Another relative wrote, "On occasion in the past we had a few problems. But since [registered manager] took over everything is going well." A health care professional wrote, "Good communication and working relationship with me." Another professional wrote, "The staff are so professional and willing to help."

Staff told us and records confirmed that regular staff meetings took place. One staff member said, "We have staff meetings for all staff. We talk about if there are any issues to be solved. People give their comments about what needs to be done." Another member of staff said, "We have staff meetings every month. The manager will give us time to talk and tell us about any changes." In addition to the meetings for all staff the

service also held meetings for just the nursing and senior staff. Records showed these were largely for the purposes of discussing clinical issues and how best to support individuals with their clinical needs.

People and relatives told us they found the registered manager to be approachable and helpful. One person said, "He's [registered manager] always around, he's a very nice chap. You can talk to him. I get on really well with him." A relative said, "When I come always his door is open, he wants to talk to me, he wanted to talk about [person that used the service] not taking her eye drops." Another relative said, "The place has got better since [registered manager] became the manager, since he got here 18 months ago. He's improved the place and the staff really respect him."

The service had a registered manager in place. They told us they had recently recruited a new position of clinical lead and that they were due to commence work the day after our inspection. Staff spoke positively about the registered manager and of the working atmosphere at the service. One staff member said, "[Registered manager] is good. He is very helpful if you need any help with anything and you come and ask him he will try to help you." The same staff member gave an example of how the registered manager had helped them, telling us, "If I am stuck writing a care plan he will explain the proper way." Another staff member said, "He is a good manager, showing cooperation." The same staff member said, "We have good teamwork here, we help each other out." Another staff member said, "He is a very good manager. If I forgot to do anything he will come and tell me nicely, not shouting. He is nice with the family and any visitors that come." The same staff member told us that the registered manager monitored the quality of care being provided. They said, "He will do a spot check and suddenly he will come on the floor and check everything and explain to us if anything is not done."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed in a safe manner. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and improve the quality of safety of the service provided. 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person must ensure that staff receive appropriate training and development as is necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a)