Glenside Manor Healthcare Services Limited

Newton House

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 15 June 2017 and was part of the Glenside Manor Healthcare Services Limited inspection. This was the first inspection for this location.

At Newton House up to 12 people with complex nursing care can be accommodated. Staff provide a service to people with neuro degenerative or previous brain injury.

A registered manager was in post. '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.'

Care plans lacked person centred detail. Clinical care needs were met and plans were generally detailed. Risk assessments in place and care plans provided clear guidance for staff. Recording charts did not always reflect care plan guidance. For example, position change charts. Also air mattresses were not set correctly and there were no checks in place. The operations manager said formats were to be introduced for staff to monitor air mattresses were set correctly.

While the medicine records showed staff administered medicines as required, procedures were not in place for staff to administer medicines prescribed when required (PRN). These procedures provide information for staff on when and why people might require additional medicines and should also include information for staff on how to recognise when people might need them. Some people had been prescribed creams or lotions. Although care staff applied these when providing personal care to people, the nurses signed the medicine recording charts. There were no transdermal patch records in place. These records ensure that staff can identify where previous patches were positioned in order to prevent placing a patch in the same place. The use of these records ensures that manufacturer guidance is followed.

"There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service. Board documents were developed from the audits undertaken which showed how the organisations were meeting their own targets and identified business development plans with areas for improvements. While audits were undertaken to assess how standards of care were being met we found the findings from this inspection had identified other areas for improvement. However the audit had not assessed the content of the care plan. For example if care plans were person centred.

People we spoke with said they felt safe and we observed positive interactions between staff and people. We observed staff treat people in a compassionate and sensitive manner. The staff we spoke with knew the people they were supporting and spoke to people with patience and explained tasks. The people at the service were not able to give us detailed feedback about the service and we saw people were treated with kindness and in a compassionate and sensitive manner by the staff. The staff we spoke with knew the people they were supporting and spoke to people with patience and explained tasks although people were

not able to respond.

The staff were able to tell us the types of abuse and the procedures for safeguarding people from abuse and avoidable harm. However, most people at the service

Staffing levels were appropriate to meet the needs of 11 people. There was a system in place to determine the number of staff required and agency staff were used where shortfalls were identified or to cover planned absences. One registered nurse and four rehabilitation assessments were on duty during the day.

Consent to care had been sought in line with legislation and guidance. Care plans contained mental capacity assessments and where people lacked capacity best interest decisions had been made.

Clear induction processes were in place and staff on induction said their training was good. Staff said they attended mandatory training set by the provider.

Staff attended core and some specialised training. Specific training needed to meet people's needs was available Staff were able to attend training in epilepsy awareness, diabetes management, person centred care and record keeping. However, there was a low take up of these subjects which could impact on the standard of care people received. There was a re-validation programme for nurses. Staff can apply for nursing degree and staff must work at the service one shift per week.

Staff were supported to perform their roles and develop their personal goals. One to one supervisions with their line manager were regular and staff said they were able to approach the registered manager with concerns. Staff were able to appraise themselves. However, the appraisals we saw were not linked to a discussion with their line manager and action plans of future goals and development needs were not part of the appraisal forms.

Some people at the service had their nutrition needs met through percutaneous endoscopic gastrostomy (PEG) tubes while others ate and drank small amounts and care plans reflected this.
Activities were limited. We saw activities coordinators in the morning reading the newspaper to people, chatting to them and involving them. In afternoon, people sat and watched a film or went back to their rooms. We found records held limited information about people's preferences such as music preferences.

The staff spoke highly of the registered manager. All said they felt involved and valued by the organisation. You can see what action we told the provider to take at the back of the full version of the report. We recommend that the service consider current guidance on the recording of applications of creams and patches to people.

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.

We observed the staff interact well with people who willingly accepted staff 's attention and their input. All staff said they felt confident to raise concerns and felt that they would be taken seriously.

Where risks had been identified, care plans provided clear guidance for staff on how to reduce the risks of harm to people. For example, moving and handling plans contained details of hoists and slings. Any additional safety requirements were also documented, such as special headwear for one person.

There were sufficient staff to support people and we observed that staff were visible and available to people.

Medicines were generally managed safely. Medication administration record (MAR) charts had been completed in full and there were no gaps in the charts that we looked at.

While MAR charts showed that when required (PRN) medicines were administered, procedures for their use were not always in place. PRN medicines were additional medicines that people might require at times for specific reasons, for example pain relief. PRN procedures provide information for staff on when and why people might require additional medicines and should also include information for staff on how to recognise when people might need them. This was particularly relevant because several people using the service were unable to communicate when they were in pain."

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to carry out their roles. Staff spoke positively about the quality and quantity of training they had access to.

All staff said they received regular one to one supervision sessions. Staff were given time to prepare for their appraisal

meeting by completing elements of the form, for example vision and values in practice and the performance assessment.

Consent to care had been sought in line with legislation and guidance. Care plans contained mental capacity assessments and where people lacked capacity best interest decisions had been made.

People had access to ongoing healthcare. The GP visited weekly and we looked at the GP review book. In this book, staff recorded which people needed to be seen by the GP, the reasons why and the outcome of the review.

Is the service caring?

Good

The service was caring.

Staff knew how to maintain people's dignity. We observed that staff knocked on people's bedrooms doors before entering and that they introduced themselves and told them what they were doing.

People's bedrooms were personalised and for some people there was a poster on the wall which was a quick guide to supporting the person. The communal areas of the building were not homely.

Is the service responsive?

Requires Improvement

People did not always receive care that was responsive to their needs.

The plans contained limited information about people's life histories prior to moving to Newton House and were clinically focussed rather than being focussed on the person's choices and preferences.

Plans in relation to clinical care needs were detailed but care plans in relation to less clinical needs, such as personal hygiene, or emotional well-being plans were limited. Some elements of the service were task focussed rather than person centred

There was an Activities Co-coordinator in post. We heard them reading the newspaper to one person and asking another what they wanted to watch on TV. There were records that showed when people participated in activities and we saw that some people had been on trips out.

Is the service well-led?

Requires Improvement

The service was well led.

Satisfaction surveys had been sent out to people who use the service and the results had been collated. There was a family forum where people and families could meet. The forum was a place where families could obtain advice and information about particular topics.

Staff said they felt well supported and valued by the provider.

While there were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service audits were not consistent with the findings of the inspection. For example, care planning processes.

Newton 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 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 was part of the Glenside Manor Healthcare Services Limited which took place over four days and on the 15 June the inspection for this location took place.

Before the inspection, we asked the provider to complete 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 reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector and an Expert by Experience. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

We spoke with one person, two nurses and one rehabilitation assistant about their views on the quality of the care. We also spoke with the registered manager, quality assurance manager, operations manager and chief executive.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included four care plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

Medicines were generally managed safely. We observed part of a medicines round with the nurse in charge. They knew people well and knew why they were prescribed their medicines. They informed people that they had their medicines and did not sign the administration chart until the medicines had been administered. There were photographs of people at the front of MAR charts which meant that staff who were unfamiliar with people would be able to recognise them. Several people were receiving their medicines via percutaneous endoscopic gastrostomy tube (PEG) and we saw that these were administered safely and as prescribed. When people were able to take their medicines orally, people's preferences had been documented at the front of the charts. For example, "Likes to take all tablets in one go and have a drink with a straw" and "Will put thumbs up when swallowed".

The MAR charts had been completed in full and there were no gaps in the charts that we looked at. This indicated that people had been administered their medicines as prescribed. When required (PRN) medicines had been prescribed to some people. These are additional medicines that people might require, for example pain relief. The administration of PRN medicines were not always detailed within people's care plans or identified separately in a protocol. While MAR charts showed that when required (PRN) medicines were administered, procedures for their use were not always in place. PRN medicines were additional medicines that people might require at times for specific reasons, for example pain relief. PRN procedures provide information for staff on when and why people might require additional medicines and should also include information for staff on how to recognise when people might need them. This was particularly relevant because several people using the service were unable to communicate when they were in pain.

There were no transdermal patch records in place. These records ensure that staff can identify where previous patches were positioned in order to prevent placing a patch in the same place. The use of these records ensures that manufacturer guidance is followed.

Some people had been prescribed creams or lotions. Although care staff applied these when providing personal care to people, the nurses signed the MAR charts. There were no body maps or guidance for care staff to follow, although care staff said they would ask a nurse if unsure where to apply the cream. The nurses said they spoke to care staff to confirm creams and lotions had been applied correctly before they signed the MAR charts. However, having topical administration charts in place would ensure that staff have the information they need at the time of applying them. It also means that the staff who administer the cream sign to confirm they have done so correctly. During our feedback with senior managers we were told the recording of these medicines were to be looked at.

We recommend that the service consider current guidance on the recording of applications of creams and patches to people alongside their prescribed medication and take action to update their practice accordingly.

Medicines were stored safely. Bottles of liquids had been dated when opened, although not all had been marked with the expiry dates. Items that required fridge storage were kept in a medicines fridge. The fridge

temperature was monitored daily as was the temperature of the clinical room. Controlled medicines were stored safely and stock levels were checked daily during handover between shifts.

Staff were knowledgeable about how to protect people from infection. They had access to personal protective equipment such as gloves and aprons and we saw that staff wore these before supporting people with personal care.

One person told us they felt safe living at the service. We observed the staff interacted well with people who willingly accepted staff's attention and their input. Staff said they had attended training on how to protect people from avoidable abuse and harm. Through scenario based questions they demonstrated their knowledge and confirmed that they knew how to report any incidents. Staff also understood the phrase whistleblowing. All staff said they felt confident to raise concerns and felt that they would be taken seriously. One said "I won't tolerate poor care, I would always speak up" and another said "There are posters in staff areas telling us how to blow the whistle".

Care plans contained risk assessments for areas such as falls, mobility and skin integrity. These had all been reviewed regularly. Where risks had been identified, care plans provided clear guidance for staff on how to reduce the risks of harm to people. For example, moving and handling plans contained details of hoists and slings. Any additional safety requirements were also documented, such as special headwear for one person. When people had been assessed as being at risk of falling from bed, assessments had been completed to ascertain whether the use of bed rails was appropriate. When the rails had been assessed as not suitable, additional safety measures were in place, such as the use of profile beds which could be lowered and crash mats.

When people had been assessed as being at risk of skin breakdown (pressure sores) the plans guided staff on how to prevent this happening. Examples included people needing to have their position changed regularly and the use of pressure relieving aids, such as air mattresses. However, the information within the plans did not always correspond with the position change charts in people's rooms, and air mattresses had not always been set correctly. For example, in one plan it had been documented that the person should have their position changed every three hours. However, the position change charts we looked at did not reflect the care plan guidance. On 14/06/2017, records showed the person had their position changed every 4-7 hours and on 10/06/2017, the chart showed the person had not had their position changed for 7 hours. This indicated that people did not always have their position changed in accordance with care plan guidance.

When people had air mattresses in situ, there was no process in place for staff to check they had been set at the correct pressure. An air mattress set incorrectly could increase the risk of skin breakdown as well as being uncomfortable for people to lie on. We looked at the air mattresses with the nurse in charge. Some of these appeared to set themselves according to the person's weight, but the nurse was unable to confirm this. Other mattresses should have been set according to people's weights. However, this was not the case. Two mattresses were set at 150 kg, but people's last recorded weights were 64kg and 66.3 kg. Another mattress was set at 81-115 kg, but the last recorded weight for this person was 60.7kg. This meant that people could be at an increased risk of developing pressure ulcers. The operations manager said formats were to be introduced for staff to monitor air mattresses were set correctly

Accidents and incidents involving people and staff were clearly recorded and reviewed by the registered manager and operations manager to ensure they had been responded to appropriately. There was a centralised electronic system in place which documented the type of incident, who was involved and the actions to take including any follow up actions. Incidents were reviewed collectively at the service level and

individually. Where required, people's care records were updated to reflect the recommendation from the outcome of investigations and any changes in support needs.

On a monthly basis, a report was generated about the previous months' incidents and reviewed for particular trends, for example a review of the records identified an increase in falls. To further reduce falls, a falls prevention programme was introduced which included looking at staff training, the environment, monitoring and review of care routines. This had halted the rising trend and falls were now decreasing. At the provider level, this information was shared with the Quality Assurance Board who monitored the wellbeing, health and safety of people and staff.

Each person had a personal evacuation plan in place which documented the support they would need in the event of an evacuation. Fire drills were regularly carried out to ensure the systems were working and staff told us they had received training around fire awareness. A poster on display defined the different fire zones and alarms were activated by zone to enable staff to know the location of a fire.

There were sufficient staff to support people and we observed that staff were visible and available to people. Comments from staff were generally positive. Staff said "generally there is enough staff, it's only when people [staff] go off sick that we might need to use agency", "Occasionally we have to use agency, but we've just recruited some more staff" and "I think we have enough staff. Mornings are busy, but we manage".

There was a system in place to determine the number of staff required and agency staff were used where shortfalls were identified or to cover planned absences. The operations manager told us that people's care and support needs were assessed prior to moving into the home. This determined the number of budgeted hours and this was reviewed annually with the clinical team. In addition, staffing levels were reviewed on a monthly basis and daily during the nurse's handover with the operations manager. Where people's care needs had changed the staffing levels reflected this.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Staff we spoke with confirmed these checks had been completed before they were able to start work.

The provider ensured information relating to DBS clearance was checked with the applicant prior to taking up their post. A risk assessment was then put into place to support the new member of staff and mitigate potential risks where appropriate. Arrangements were in place to ensure that existing staff renewed their DBS every three years.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills to carry out their roles. Staff spoke positively about the quality and quantity of training they had access to. Nurses said they were able to complete training in order to meet their professional requirements and that they had been supported through the revalidation process with the Nursing and Midwifery Council. They said they attended service specific training, for example tracheostomy care, catheterisation and venepuncture. Care staff also said they had access to training. One said "They (the provider) are going to support me to undertake my nurse training; they will even pay my university fees".

All staff said they received regular one to one supervision sessions, although some were unsure how often these should happen. Staff also said they had annual appraisals. An electronic matrix was maintained of the date of the last staff appraisal and when the next appraisal was due. Staff were given time to prepare for their appraisal meeting by completing elements of the form, for example vision and values in practice and the performance assessment. The format of the appraisal form we looked at did not easily identify the staff member's personal objectives and performance goals, or those which were outstanding. This could result in staff not recognising and achieving the standards required of the organisation."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Deprivation of liberty authorisations had been sought. The authorisations we looked at had no conditions in place. Staff understood the principles of the Mental Capacity Act and understood what a DOLs authorisation was.

Consent to care had been sought in line with legislation and guidance. Care plans contained mental capacity assessments and where people lacked capacity, best interest decisions had been made. The documentation in place was detailed and showed how the decisions had been reached and who had been involved in the process. In one person's plan it had been documented that an IMCA (Independent mental capacity advocate) had been requested because the person had no family to contribute to any best interest decisions.

Most people living at the service were unable to eat or drink normally because of their medical conditions. In these instances, people were receiving their nutritional input via percutaneous endoscopic gastrostomy tube (PEG's). Care plans contained details of people's feeding regimes and guidance for staff on how to

provide mouth care to ensure that people's mouths remained clean and moist. The plans also detailed where people had been assessed as being at risk of choking and guided staff on how to prevent this happening. For example, in one plan it was documented that the person should be in an upright position.

Where applicable, people had been reviewed by Nutrition nurses and by the internal Speech and Language team (SALT). For example, in one person's plan it had been documented that since living at Newton House, their swallow reflex was recovering. The plan detailed the guidance from the SALT team on how staff should support the person to have small amounts to eat and drink. However, details of people's preferences in relation to food and drink had not been documented. For example, in one person's plan it had been documented that following review by the SALT team, they could have a "Grade D" consistency diet. It had been documented that the person liked tomato sauce, mayonnaise and barbeque sauce, but nothing else in relation to the type of food the person liked. Staff said "I know they like chocolate", but this had not been documented. People's weights were monitored regularly.

People had access to ongoing healthcare. The GP visited weekly and we looked at the GP review book. In this book, staff recorded which people needed to be seen by the GP, the reasons why and the outcome of the review. In addition, records showed that people had been reviewed by the SALT team and the tissue viability nurse for example.

The communal areas of the building were not homely. The décor generally was "tired" We discussed the general décor of the home with staff. The staff told us the home was due to be repainted.

Good

Is the service caring?

Our findings

We saw positive interactions between staff and people using the service. We observed a new member of staff have good knowledge of the person they were supporting. We saw this member of staff use patience and encouragement when needed. Staff knew people's needs and there was a calm and friendly atmosphere. However, one person said when agency staff was used their care was not from staff that knew them. This person said the staff were "really friendly" but that "more staff were needed as they use a lot of agency who don't know me. A lot of them are not nice at all. They don't hurt you physically but they treat you like a piece of meat. It isn't all of them but they treat you like it is just a job." This person was not able to give us the names of the staff or describe their appearance and stated "No I couldn't even point one out as I rarely even see their faces because of how I am lying in the bed. It sounds like I am making a big deal of it." We reassured this person who thanked us for listening and we passed these concerns to the registered manager during feedback

Staff showed concern for people's well-being. They spoke to people kindly and continued to speak to them despite some people being unable to respond. They asked them what they wanted to watch on TV, and were they comfortable. When one person was brought into the lounge, the staff member asked if they wanted the DVD rewound so they could watch it from the beginning.

Staff knew how to maintain people's dignity. Personal care took place behind closed doors for example; although on one occasion we did observe a member of staff emptying someone's catheter with the bedroom door open. Staff said, "I always keep people covered up as much as possible when washing them, I close the door and curtains". We observed that staff knocked on people's bedrooms doors before entering and that they introduced themselves and told them what they were doing.

Staff spoke highly of their role. Comments included "I know I help people here. If it was my family, I'd want them to be well looked after, so I make sure that's what I do" and "I know we give good care here, all of the staff are very good at what they do". One said "We have a really good team here. The staff are so good and so passionate about what they do. I get a huge amount of job satisfaction".

People had access to communal gardens and we saw that some people sat and looked out of the window. Staff said that weather permitting they could take people out in their chairs to enjoy the gardens.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. The plans contained limited information about people's life histories prior to moving to Newton House and were clinically focussed rather than being focussed on the person's choices and preferences. People's bedrooms were personalised and for some people there was a poster on the wall which was a quick guide to supporting the person. In addition, where life history information had been documented, it was held within a separate file from the care plan. The information was in a separate file but the information had not been drawn together and used to inform the care plans. This included areas of support the person was able to perform independently and their preferences on how staff were to assist them.

Plans in relation to clinical care needs such as tracheostomy care, PEG care and feed regimes were detailed. They provided clear guidance for staff on how to ensure people received the clinical care safely and effectively. But, plans in relation to less clinical needs, such as personal hygiene, or emotional well-being plans were limited. For example, in one person's plan in relation to their hygiene needs, it had been documented that the person preferred a bath or shower "twice a week". There was nothing documented in relation to whether the person preferred a wet shave or a dry shave, which toiletries they preferred or the kind of clothes they liked to wear. In another person's plan it had been documented that their family had decorated their room with pictures and photographs, but there was nothing detailed who the family members were, despite it being documented within the plan that staff should "talk about his family".

We looked at the wound care plan for one person. A body map had been completed, but the wound assessment had not been completed in full every time the wound had been redressed. The dimensions of the wound had not been consistently documented, and because no photographs had been taken of the wound, it was difficult to accurately assess whether the wound was deteriorating or improving.

Some elements of the service were task focussed rather than person centred. We found staff maintained charts and report logs in one file about people's personal regimes which evidence institutional practices. For example, the day's people had showers instead of their preferred routines. There was a bowel chart for every day, where staff documented when people had their bowels opened, despite the fact that this information was duplicated within people's daily records.

There was an Activities Co-coordinator in post. We heard them reading the newspaper to one person and asking another what they wanted to watch on TV. There were records that showed when people participated in activities and we saw that some people had been on trips out. However, care plans lacked detail in relation to activities or pastimes that people wanted to participate in. For example, in one person's plan it had been documented that they were "religious". Staff said "People from a local church come in and do a service for him regularly", but this detail was not within the care plan. We saw and heard that the same person enjoyed listening to loud music in their room. However, the plan only detailed "likes listening to music". There was nothing documented to say which music the person preferred staff to put on for them, or that they preferred to listen to it at high volume.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014"

There was a clear process in place for people and families to raise a concern. A copy of the provider complaints procedure was displayed in the home. In addition, easy read leaflets called 'Talk to Us' explained how to raise a concern and these were available in the entrance to the home.

Comment cards and a comments box were also in situ, where people could raise concerns, put forward suggestions or voice their opinion. Any concerns raised were acknowledged within two working days and responded to within 20 days. There had been no complaints raised during 2017.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service. However, audits had not identified all shortfalls identified at this inspection. For example, monitoring of equipment was not taking place, procedures for when required medicines were not in place and person centred planning was not introduced.

Care plan audits were targeted for monthly review. The audit consisted of areas of care, for example communication and mobility and assessed if these care plans had been reviewed with the person and family. It also looked to see if the summary of needs had been updated and that documents noted within the index were present. The care plan audit did not identify that person centred plans were not in place. In addition, if there was sufficient detail and guidance to enable a consistent approach to the person's care and support.

The Health and Safety audit assessed the environment, hand hygiene, personal protective equipment and waste disposal. A traffic light system was used to assess the standards. For example, red where the standard was unmet and green for standard met. We noted that where there was a shortfall the standard was re-assessed the following month. For example, shortfalls with records on the quality of bed cover for mattresses. The audit had identified that members of staff didn't know how to check records or even where to find the records.

A Health and Safety risk register was in place and all areas of risk were assessed and a score given for the level of action needed to minimise the risk. For example, fire safety had an amber rating and moderate action was needed. Fire Risk assessment action plans were to be completed by registered managers by June 2017. Infection control was also identified as amber and moderate action which included enhanced procedures were to be in place.

Board documents were developed from the audits undertaken which showed how the provider were meeting their own targets and identified business development plans with areas for improvements.

Satisfaction surveys had been sent out to people who use the service and the result had been collated. The Quality and Patient Safety Lead told us there had been variable scores for some of the question such as, staff spend enough time on the things that are important to me, staff do things the way I want them done, I am treated like an individual and I feel I have control over the care I receive. There had been some feedback about staff not fully communicating with people by using the communication aids in place. We were told the manager was going to work with the team to ensure everyone is competent in using the communication aids that are in place for individual people.

The forum was a place where families could obtain advice and information about particular topics, for example at the next forum taking place in June 2017, speaker offering free legal advice would be attending.

Staff said they felt well supported and valued by the provider. One said "I do feel like a valued employee. The [chief executive] CEO knows us by name. I really do feel appreciated". Other comments from staff included "Generally I think staff are quite happy. This is not a stressful place to work and I think that is reflected in the care" and "Morale is up and down, like most places, but generally it's good".

Senior staff nurse meetings took place monthly. We saw the minutes for April 2017 where people's risks and needs were discussed and used as a learning opportunity. Staff said they attended regular staff meetings. In addition, nurses said they attended regular clinical meetings where they had the opportunity to share best practise. One said "The manager is very open and really listens to our thoughts and ideas. I feel included" and "Communication is very good, we feel involved".

A relative stated 'thank you for the excellent level of care and communication through my loved ones stay'. A member of staff who was leaving their employment stated 'I have enjoyed being a part of the team and am thankful for the opportunities you have given me'.

There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service. However, audits had not identified the monitoring of equipment, procedures for when required medicines and person centred planning.

Care plan audits were targeted for monthly review. The audit consisted of areas of care, for example communication and mobility and assessed if these care plans had been reviewed with the person and family. It also looked to see if the summary of needs had been updated and that documents noted within the index were present. The care plan audit did not identify that person centred plans were not in place. In addition, if there was sufficient detail and guidance to enable a consistent approach to the person's care and support.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care pans were not person centred and lacked detail on how staff understood the person preferred their care to be provided. People's life histories were not included in the active care plans