Glenside Manor Healthcare Services Limited

Limetree

Inspection report

Warminster Road
South Newton
Salisbury
Wiltshire
SP2 0QD

Tel: 01722742066
Website: www.glensidecare.com

Date of inspection visit:
13 June 2017

Date of publication:
22 September 2017

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

Limetree is located within the Glenside Hospital grounds and can provide accommodation for up to 26 adults with acquired or traumatic brain injury, or other neurological conditions.

This inspection was unannounced and took place on the 13 June 2017.

A registered manager was in post and was recently appointed. '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 said they felt safe living at the service. Although staff knew the types of abuse and had attended training in the procedures for safeguarding vulnerable adults from abuse they were not clear on the actions needed for suspected abuse.

Risk assessments were in place for some identified risks. The staff we asked knew the actions needed to minimise risks. For example, choking and falls. The action plans were not clear on how staff were to use products such as thickeners for people at risk of choking and the settings for equipment such as air mattresses. This meant some people were at increased risk. When these shortfalls were identified the registered manager and operation's manager took prompt action to ensure risks were mitigated. Where people's fluid was monitored the daily target or the total intake of fluid was not recorded on the fluid balance sheets. This meant the registered manager was not aware of people whose fluid intake was low.

Staff said the staffing levels were decreasing and the needs of people were not recognised which meant sufficient staff were not on duty to meet people's needs. The manger and operations manager said this was staff perception and initiatives such as task lists were introduced to show to staff they had sufficient time for task and for one to one time with people.

Safe recruitment processes were in place. Candidates were able to use their preferred method of application form which included CV to apply for vacant posts. Disclosure and Barring Services (DBS) must be approved before the staff start working at the service. A Disclosure and Barring Services (DBS) check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Where staff had disclosed convictions or cautions they were investigated and risk assessments completed to ensure staff were safe to work with people.

Medication administration charts (MAR) were signed to show the medicines administered. However, the charts were not signed immediately after medications were administered by the nurses. Application charts were not used by rehabilitation assistants (RA) to document the application of topical creams. The procedure was for RA to confirm to the nurse who will then sign the MAR. The operations manager said the method of recording topical cream would be reviewed. The number of medicine errors has reduced since

changes of the supplying pharmacy for medicines.

Induction of new staff was detailed and there was ongoing reviewing of the process. Staff on induction said the induction was good. There was mandatory training set by the provider which staff attended to ensure they had the skills needed to meet people's needs. There was a re-validation programme for nurses.

While training was available to staff on person centred care and to meet the needs of people living with dementia not all staff had taken the opportunity to develop their skills and knowledge in this area. Staff can apply for nursing degree and during their training these staff must work at the service one shift per week.

Appraisals of staff with the registered manager were annual. Part of the appraisal system was for staff to appraise themselves. The appraisals viewed did not include the discussion with the registered manager and the action plan on goals for the year was not included in the appraisal records. This will ensure staff were confident and skilled to perform their role.

People were subject to continuous assessments. Staff's awareness of Deprivation of Liberty Safeguards (DoLS) procedures was variable and their knowledge depended on their role in this area. Staff's understanding on the principles of the Mental Health Act was based on how to support people with making day to day decisions.

People's ongoing healthcare needs were met and referrals to specialist healthcare professionals were made for further investigations. We saw that following visits healthcare professionals documented the outcome of their visits. People had access to internal support e.g. Speech and Language therapists and Occupational therapists.

Care plans were varied and were not person centred. Clinical needs were made clear in the care plans but they lacked person centred approach. While people's background histories, relationships and preferred routines were gathered the information was not used to develop care plans. Care plans lacked people's preferences on how staff were to deliver their care. This meant staff were not given information that identified the person as an individual.

Behaviour management plans were in place and the quality of the information was variable. For one person the information was inconsistent with other documents that related to the same area of need. Staff recorded incidents of aggression on Patient Observation (OS) charts which showed behaviour management plans were not consistently followed. There was no evidence that the charts had been analysed and the care plan reviewed following an incident. We were shown the charts to be introduced and will give more detailed information for staff to identify triggers. We were told the new formats will allow for analysis of frequent behaviours.

People knew who to approach with complaints. There were processes for making complaints to be used for the investigation of formal and informal complaints. Complaints received were investigated to a satisfactory outcome.

"You can see what action we 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 always safe

We observed staff interacted well with people and we did not see any signs of distress from people when staff were present. A relative said their family member was safe living at the service.

Some staff were not clear on the procedures for safeguarding people from abuse. The registered manager said during one to one meetings safeguarding procedures would be clarified and more structured discussions with staff would take place.

Risk assessments relating to tissue viability, nutrition, moving and handling, and falls were developed. We found some risk assessment action plans did not give staff clear guidance on how they were to use equipment and products.

People's needs in relation to medicines were clearly documented in care plans. Medicine Administration Records (MAR) charts were completed.

Is the service effective?

Good

The service was effective.

Staff were supported to undertake their roles and responsibilities. One to one supervision meetings with their line manager and group supervision through team meetings were organised. However, staff had not taken the opportunity to attend available dementia awareness training although people with these cognitive impairments were living at the service.

People told us who helped them make decisions. Members of staff gave us examples on how they enabled people to make decisions.

People told us they liked the food served. There was a choice of drinks available at all times.

Records in people's care plans indicated that they had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

The people we spoke with said they "liked" the staff. We observed staff were attentive and there was good-humoured interactions between staff and people. However, there were examples of when staff did not respect people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans relating to people's health and physical needs were comprehensive and contained details which were specific to them. However care plans were not person centred as they did not always include the person's preferences on how staff were to deliver their personal care.

Behaviour management plans were in place for people with cognitive impairments and acquired brain injury who showed their frustration using aggression. Overt Aggression (OS) charts were used to document incidents of aggression and physically challenging incidents. However, the charts were not clear and there was no evidence that the charts had been analysed to develop behaviour plans on how to respond to triggers.

People were supported to participate in group activities and one to one activities were provided to people who preferred not to join group activities.

People said they were able to raise concerns. There was a clear process in place for people and families to raise a concern.

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 had opportunities to 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.

There were systems in place to monitor and assess the quality of the service. However, our findings were not consistent with the assessments of the service. For example, the audits had not identified that care plans were not person centred but had assessed the documents to be included

Limetree

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 13 June 2017 and was unannounced.

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 two inspectors and one was the lead 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 three people, one relative and six staff including nurses, rehabilitation assistants and activity coordinator. We also spoke with a clinical psychologist, 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 six care and support 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

People felt safe living at the home. One person said they felt safe and the staff made them feel safe. We observed staff interacted well with people and we did not see any signs of distress from people when staff were present. A relative said their family member was safe living at the service.

While the two staff, with prompting knew on the types of abuse, they were not clear on the procedures for safeguarding people from abuse. One member of staff said the purpose of the procedure was to "keep the environment safe for people" but that other staff were available with guidance if needed. The other member of staff said the procedure was making sure service user is not put at risk for example; bed heights and removing obstacles such as maintain pathways free from trip hazards. The training matrix showed staff had attended safeguarding of vulnerable adults procedures. The registered manager said safeguarding of vulnerable adults procedures were discussed at one to one meetings. This registered manager said during one to one meetings safeguarding procedures would be clarified and more structured discussions with staff would take place to ensure that all staff was aware of the action to take in the event that they suspected or observed abuse.

Arrangements were in place to manage some risks. The staff were knowledgeable about the actions needed to manage risks. Risk assessments relating to tissue viability, nutrition, moving and handling, and falls were developed. A member of staff said referrals for dietician input were made for people that were not maintaining their weight and staff monitored people's weight and supplements were prescribed.

We found some risk assessment action plans did not give staff clear guidance on how they were to use equipment and products. For example: two people had been assessed as being at risk from choking and had been prescribed a thickener for use in their drinks. We found that there was conflicting information regarding the correct amount of thickener to be used. We told the registered manager and senior nurse of our findings as using the incorrect amount of thickener may increase people's risk of choking. The registered manager took prompt action to ensure staff had the correct guidance for thickening fluids.

Two people assessed as being at risk from developing pressure ulcers had pressure relief air mattresses on their beds. We found that the inflation pressure of the mattress had been set too high for their weight. One person, who weighed 58.0 kg, had a mattress set at 81 – 115 kg. The other person's had been set at 150 kg, whilst they weighed less than this. Incorrect inflation pressures increase the risk of tissue damage. We told the nurse on duty of our findings. The registered manager told us a form was to be introduced for staff to ensure mattresses were at the correct setting.

Fluid charts were not always fully completed or the total amount of fluids required stated. The total intake for the day was not being recorded. This meant that nurses could not always be sure people who were at risk of dehydration were receiving adequate hydration.

One person's care plan contained comprehensive information regarding how they should be moved from

their bed to their chair, along with photographs of how they should be seated in order to maintain correct posture. We saw that a comfortable chair, specific to their needs, had been provided and appropriate moving and handling equipment was available. The same person had been assessed as being at risk of falling from their bed. We found that they were in a height adjustable bed and that this had been put at its lowest setting. A cushioned floor mat had also been placed alongside their bed.

A national pharmacy provided the majority of medicines. Each person's medicines were kept in an individual container within the medicine trolley. Registered nurses were responsible for the administration of medicines. We observed a nurse on part of their medicine round and saw that they were organised and demonstrated an awareness of the needs of the person they administered the medicines to. However, the nurse waited to the end of their lunchtime medicine round before signing each person's medicine administration record (MAR) sheet. This is seen as a risk as it may lead to recording errors; which in turn could lead to administration errors.

A selection of medicine administration records (MAR) were reviewed. Photographs of people were attached to the MAR sheet and any medicine allergies were recorded. MAR sheets were completed and there were no gaps on the sheets reviewed apart from some relating to the application of topical medicines, in this case body creams. Where one person required the use of a transdermal patch, the area of the body that the patch was adhered to was recorded and changed at each application in order to prevent skin irritation.

MAR sheets had been pre-printed by the pharmacy. There were occasional hand written amendments and additions. This was when staff had transcribed details of a prescription or alteration onto the MAR. We found that hand written amendments had been signed by the person who did the transcribing and that a witness signature had been obtained. Signing hand written amendments and getting them witnessed is seen as good practice as it reduces the risk of transcription errors.

Where topical medicines such as creams and ointments were prescribed, these were mainly administered by the RA's. The nurse stated that the RA's would tell them that they had administered the topical medicine and that the nurse would then sign the MAR.

The home did not currently use Topical Medicine Administration records. These are completed by the staff that administer the medicine and contain full instructions regarding the areas to be applied to, the frequency and type of cream or lotion. Body maps, to specifically indicate which area of the body the topical medicine should be applied to, could also be used. The use of Topical Medicine Administration records and body maps is seen as good practice as it improves the rate of application and recording of these prescribed medicines.

The receipt of medicines was being recorded on MAR sheets and witnessed by two staff and also signed as witnessing any disposals of medicines.

People's needs in relation to medicines were clearly documented in care plans. Information included the use and effects of medicines and plans for 'as required' medicines that stated the criteria for administration, dosage, maximum quantity and contra-indications. This is seen as good practice as it directs staff as to when, how often and for how long the medicine can be used and improves monitoring of effects and reduces the risk of misuse.

One person said "I would like to see more staff. They don't have time to stop and chat to you". The manager said there were normally four rehabilitation assistants (RA's) and one nurse on duty during the day for 13 people. At night there were two RA's and one nurse. Sometimes there would be more than one nurse on

duty, in which case they would work as a RA during their shift.

One staff member said "Sometimes it's tight with five as you have one [staff member] doing a one to one. Lots of people are needing two carers, so we're pushed." Another member of staff said "it's a struggle with staff". They said previously the staffing levels were five carers and one nurse and this was reduced to four carers and one nurse without any explanation.

The third member of staff said more staff were needed for the number of people and when staff were undertaking other tasks people were left unsupervised particularly as "three people targeted each other, some people needed support with eating and some will go into other people's room." This member of staff confirmed that staff re-directed people who made attempts to enter other people's room. They explained the tasks that staff were undertaking which they said restricted the support people received. For example, some people had one to one which was included in the staffing levels, "two staff and at times three staff were needed" for personal care and when the nurse was undertaking other tasks such as medicine administration.

The Operations manager said staff shortages were the perception of the staff and initiatives such as task lists were introduced to show to staff they had sufficient time for task and for one to one time with people. We observed that people had their care and support needs met during our visit.

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

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. Each home had a poster of the different fire zones and alarms were activated by zone to enable staff to know the location of a fire.

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.

There were clear procedures in place to deal with staff disciplinary issues. We reviewed staff files which demonstrated the process of dealing with any performance issues informally before escalating to formal action. This was in line with the provider policy.

Good

Is the service effective?

Our findings

A member of staff said their induction was over two weeks and included moving and handling, safeguarding of vulnerable adults from abuse, infection control and positive behaviour management training.

Staff were supported to undertake their roles and responsibilities. One to one supervision meetings with their line manager and group supervision through team meetings were organised. Staff said one to one meetings with their line manager were regular. A member of staff said one to one meetings were a two way discussion where their performance and areas for improvement were discussed as well as their training needs.

A member of staff said they had recently attended a session with a clinical psychologist where staff were given guidance about positive behaviours. Another member of staff confirmed they had not attended any mental health care needs and dementia training although people with these cognitive impairments were living at the service.

People who use the service had additional support needs which required specific skills set from the staff. Staff were given opportunities to complete a wide range of training, examples of mandatory training as set by the provider included health and safety, infection control, food hygiene, safeguarding vulnerable adults, Mental Capacity Act 2005, manual handling and MAPA (management of actual and potential aggression). Training was offered twice a month in the mandatory training subjects. We found although available to staff and there were no constraints on attending this training staff had not taken the opportunity to attended training in dementia awareness and person centred approach.

There was a training matrix in place which evidenced the training which staff had completed and subjects which required refresher training. Staff told us they had "excellent training" and "really good training opportunities". Training was delivered through face to face sessions where staff could discuss and evaluate their learning. The operations manager told us they fully supported the different ways in which their staff learnt. There was additional support where English may not be the staff member's first language or where there may be potential barriers to learning, such as dyslexia.

"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). Members of staff confirmed people's

access was restricted and were subject to continuous assessments and were not able to leave the home without staff support.

People told us who helped them make decisions. One person said "my family help me with making decisions" and another person said "we [staff] talk about it and find a compromise. We have a choice of food".

Members of staff gave us examples on how they enabled people to make decisions. A member of staff said for one person visual choices were shown and people were encouraged to make the decisions on the meal options available. For example, people were asked if they preferred a soft diet. Another member of staff said people were asked before undertaking tasks and their decisions were respected. They said where people had communication needs pictures were used to help identify the person's mood. For example, pictures of happy and sad faces.

People told us they liked the food served. There was a choice of drinks available at all times. A staff member felt that the meals had improved saying "The menu is improving, there's more choice and flavours; and now we can get pureed puddings." Another member of staff told us there was a four week rolling menu based on people's likes and dislikes. This member of staff said that at weekends the menu changed and a full "English cooked breakfast" was served on Saturdays. In the kitchen there was a list of people's preferences which included drinks, how meals were to be served and specific diets to be served. We noted from the menus that a continental style breakfast was served which included a variety of cereals and toast, a cooked meal was served at lunch and a lighter meal for tea. At tea time we saw people were able to choose the soup and sandwiches from a variety available and desserts.

People who required assistance to eat their meals received individual attention from staff. They were not hurried and people were able to swallow what they were eating before continuing.

One person who initially was of low weight and required enteral feeds via their PEG tube had steadily gained weight over the last year. Another person had continually lost weight. We found that they had been promptly referred to their GP, specialist nurse and dietician.

Records in people's care plans indicated that they had access to healthcare professionals such as general practitioners (GP) and opticians. People also had access to internal healthcare professionals such as clinical psychologists, physiotherapists, occupational therapists, speech and language therapists, dieticians and podiatrists.

A GP visited Limetree each Thursday. The registered manager told us that a GP was available every weekday on the Glenside site. This meant that people were able to see a GP at short notice if required. We saw recorded for one person where staff had recorded the outcome of visits from the GP. This included details of referrals to other healthcare professionals such as physiotherapists.

Good

Is the service caring?

Our findings

The people we spoke with said they "liked" the staff. One person said the staff were caring and another said the staff were "lovely". We observed staff were attentive and there was good-humoured interactions between staff and people.

People told us the staff respected their rights. The comments made by people included "staff always knock on my door" and "yes they do they knock on my door before coming in". However, whilst being showed around the home during the morning we noticed that a bedroom door had been left open and a member of staff was assisting a person to dress in full view of anyone passing. The manager took immediate action and the staff concerned approached us to apologise and to explain the circumstances of the event. These staff confirmed that delivering personal care while bedroom doors were open was an isolated incident. Some people who required assistance to eat their meals received individual attention from staff. These people were not hurried and people were able to swallow what they were eating before continuing.

A member of staff explained they developed relationships with people by introducing themselves to the person before undertaking tasks and spending time with people. They said "we ask people about their family life during personal care".

When a person was showing signs of distress the staff used distraction techniques which quickly diffused the situation. A member of staff said that when people showed signs of distress they reassured the person. They said diversion techniques used included asking people the actions staff needed to take to prevent them from becoming angry or frustrated.

Another member of staff said developing trust ensured people felt they mattered and stated "we want the best for them." This member of staff explained that staff had a responsibility to ensure they adhered to codes of conduct as their behaviour had an impact on people. They acknowledged the staff were working in people's home and "having a laugh" with them was important. It was also stated that people were able to make decisions and "if people say no it's their decision."

The likes and dislikes and preferred routines were included in one of the three files kept on people. A member of staff said care plans were updated where people changed their preferred routines. For example, one person refused their personal care in the morning and staff amended the care plan for the person to have this at night.

At lunchtime, meals were served either in the dining room, lounges or in people's rooms if they wished. We saw that, when a person did not like the choices on offer, then they were provided with something that they would like. One person said that they would like a sandwich and another some toast, which the staff made for them.

Requires Improvement

Is the service responsive?

Our findings

Some people knew they had a care plan. One person identified the staff whom they had review meetings with.

Care plans were based on the person's assessment of their personal needs which included medicines, communication, mobility, personal care, elimination, nutrition and behavioural support. However care plans were not person centred as they did not always include the person's preferences on how staff were to deliver their personal care. Where people's preferences were included in the care plan there was no evidence to show the staff had respected these preferences. For example, the care plan for one person stated the person preferred female staff but the action plan stated two male staff was also acceptable.

A member of staff told us there was an expectation that staff read care plans during induction and during handovers the staff arriving on duty were given information on people's current needs. They said "a lot of information. Body maps and the notes are good." Another member of staff said they read the care plans and the information included helped ensure people's needs were being met.

A 'summary of needs' was available at the start of peoples care plans. This was a concise description of the persons needs designed as a quick reference guide for staff. However, two summaries seen had not been dated. One summary had been reviewed in the month prior to our inspection and stated 'no changes to care plan', however some of the information differed from that in the care plan. For example; the summary of one person's enteral feeding regime differed from that in their care plan for nutrition. This could increase the risk of people receiving care and support, which did not meet their current needs.

Some care plans relating to people's health and physical needs were comprehensive and contained details which were specific to them. For example, one care plan for personal care, detailed the approach staff should take as the person could occasionally become aggressive. Another contained detailed information and records regarding the care of their PEG tube. However the same person's care plan lacked detail in relation to tissue viability. The care plan stated 'is nursed on a pressure relieving mattress' but did not state the type required, whether it was an air mattress (as was the case) and if so, what inflation pressure was required.

Behaviour management plans were in place for people with cognitive impairments and acquired brain injury who showed their frustration using aggression. The behaviour plans were not fully person centred and showed little evidence that people were involved in the preparation of their plans. We also noted from the reports of aggressive incidents that staff were not always following the guidance given in the behaviour plans. The report from the clinical team meeting dated 5 April 2017 stated that "the behaviours can depend on the staff's approach [to the person]. XX behaviour is driven by your response to her." We saw recorded on 19 May 2017 "she kept on about having the television on during personal care which staff found distracting to XX as she does not comply or listens to instructions so we switched the [television] off to prevent this. This makes her agitated and distressed and becomes behavioural."

The personal care plan for this person stated they preferred their personal care at 7:30pm and if this was done later they became distressed. We noted this person had shown aggression during personal care. The Overt Aggression chart showed personal care was provided at 9:30pm, 10:00pm and 10:30pm. On 7 June 2017 we saw staff had recorded "XX at start of the shift was still asleep and staff decided to get her up and out of bed".

Overt Aggression (OS) charts were used to document incidents of aggression and physically challenging incidents. Staff documented the date, time and the activity which included the behaviours exhibited before and after an event and the intervention from the staff. However, the charts were not clear and there was no evidence that the charts had been analysed to develop behaviour plans on how to respond to triggers. Staff attended training on safe holds and where these were used incident forms were completed which the registered manager reviewed and analysed for patterns and trends. The Overt Aggression charts were completed following an aggressive incident and indicated the person was showing signs of distress before the challenging behaviours was exhibited but staff continued with the task and the intervention from staff included ignoring the aggression, using prompts and observation.

We noted that 12 incidents of these behaviours followed with quick succession. However, distraction techniques were not used, a clear description of the incident was not given and the care plans were not reviewed following each incident. The clinical psychologist told us the OS forms were to be reviewed, new forms were to be introduced and staff were to receive training on understanding behaviours. They said before the introduction of new support plans there was to be a process for gathering information on behaviours. A recording format was to be used initially to assess the frequency of behaviours and the analysis was to assist staff to understand the behaviours exhibited. Following from the analysis care plans were to be introduced which included the person's background history, management of behaviours as well as proactive and reactive strategies. The escalation of behaviours and management with post evaluations were to be part of the care plans.

The home's policy was to review individual care plans and assessments each month. This was recorded in the progress and evaluation section of the plan. We found that this did not always occur. For example one person's progress and evaluation record for nutrition had not been completed since 23 April 2017 and their tissue viability assessment (Waterlow) had not been recorded since 3 March 2017.

Daily reports were completed. Entries were made by a range of staff, such as rehabilitation assistants, nurses and therapy staff. These reports were task led and included the tasks undertaken, intake of food and fluid and if the person had taken their medicines.

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

A nurse on duty was knowledgeable about the principles of a person centred approach. They knew that some behaviours exhibited were due to poor communication, staff not meeting people's needs and pain.

People were supported to participate in group activities and one to one activities were provided to people who preferred not to join group activities. An activities coordinator was employed and although on a period of absence at the time of inspection was available to give feedback on the arrangements for activities. They said the weekly time table was organised into themes and outings were also organised. This coordinator said the range of activities were based on "the things that were natural for people to make" which included carpentry and upholstery. They said people undertaking upholstery activities made their relatives Christmas gifts.

Activities were held from 8am to 4:30pm excluding weekends and there were guidelines on the types of activities for staff to undertake at weekends which includes quizzes and games. We saw on display minutes of residents meetings and photographs of activities and outings. For example, visits to the zoo, upholstery classes and people making bird boxes.

People said they were able to raise concerns. One person said "I complain to the staff and it is resolved. Yes I know how to make a complaint". A relative of a person living at the service said they would go to the office if they had complaints.

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.

Requires Improvement

Is the service well-led?

Our findings

While care plan audits were targeted for monthly review the assessment was not consistent with the finding of the inspection. 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. The care plan audit did not identify that the quality of the recording was person centred, if the appropriate risk assessments and monitoring charts were complete and in place or removed when not required. In addition, if there was sufficient detail and guidance to enable a consistent approach to the person's care and support. The manager had identified that person centred care plan were not in place and told us they had to be introduced.

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 organisation was meeting their own targets and identified business development plans with areas for improvements.
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 there were shortfalls and these re-reassess the following month. For example, activities room requires new chairs.

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.

People said their view about the service was gathered through residents meetings and surveys. Staff said there were team meetings where information such as policy changes and issues were discussed. A member of staff said that staff were able to express their opinions at team meetings. The manager told us staff meetings were regular and these forums were used to exchange information and to involve staff in changes of routines and processes.

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, for example at the next forum taking place in June 2017 a speaker offering free legal advice would be attending

A registered manager was in post. A member of staff said the new registered manager was good and the team worked well together. They said there was a sense of humour in the workplace. Another member of staff said before the manager was appointed the deputy manager was in charge and the appointment of the new manager was a "positive move". They said changes were being introduced; the staff were involved in

the introduction of change and the "changes had made things better."

The registered manager said the vision was to develop the service and discussed the challenges with changing the existing culture to a more person centred approach. The manager said staff had to be given time to adjust to change and the introduction of change has to be slow. The management style was described as shared responsibility although depending on the situation the approach may be task led while promoting an "open and approachable" culture.

Internal audits to assess the quality of the provision were undertaken. Medicine audits were undertaken monthly by an external company. Audits were undertaken by the leads in this area for example infection control and Health and Safety were done by the manager responsible.

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 plans were not person centred and did not include people's preferences on how their care was to be delivered by the staff. People were not involved in the development of their care plans.