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

Newton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide nursing and personal care for up to 12 people with complex nursing care needs. At the time of the inspection 10 people were living at the service.

The inspection took place on 29 and 30 August 2018. The first day was unannounced.

At the previous inspection on 15 June 2017 we found improvements were required because care plans were not person centred and lacked details of people's preferences for how they wanted their care to be provided. People's life histories were not included in care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made; however further work was needed.

There was a registered manager 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.

Quality assurance systems did not always identify shortfalls found during this inspection. There were quality assurance systems in place; however, the lack of consistently person centred care planning had not been identified during audits.

Care plans were not consistently person centred; although the registered manager said work had begun to rewrite plans this had not been completed.

We saw examples of task focussed care rather than person centred care. Staff told us that night staff regularly washed two people before the day shift arrived "to help us [day staff] out." There was a list which showed people had a bath or shower a set day each week rather than as often as they liked. Most of the staff we spoke with were unfamiliar with the term 'person centred care'.

Staff had been trained to keep people safe. People using the service and their relatives told us they felt safe. Care plans contained risk assessments. When risks were identified the plans provided clear guidance for staff on how to reduce the risk of harm to people. At the previous inspection we found there was no process in place to check air mattresses were set correctly. At this inspection a checking process was in place, but it was not effective because 7 of the 8 air mattresses we looked at were set incorrectly.

Medicine administration records showed people had received their medicines as prescribed. However,

protocols to inform staff when to administer as required (PRN) medicines were not in place. These protocols 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. This meant nurses were signing the MAR without being involved in the procedure. 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. All of these issues were highlighted during the last inspection.

The environment was not always clean. We saw dirty floors and dirty crash mats beside people's beds. Door frames were scuffed and chipped. The kitchen flooring was not fully sealed and there was a hole in the linoleum. This meant it would be difficult to ensure the environment was free of infection.

Incidents and accidents were reported and analysed to identify trends. There was evidence that lessons were learned when incidents happened.

Comprehensive pre-assessments had been completed before people moved to the service.

Staff were trained to undertake their roles. Staff had regular supervisions with a supervisor.

There was enough staff on duty to meet people's needs. Although there was regular use of agency staff, these were block booked in order to ensure continuity of care.

Consent to care was sought in line with legislation and guidance.

People using the service spoke highly of the permanent staff and were happy with the support they received. One person told us they didn't feel agency staff offered the same level of support as other staff with their communication needs. We observed positive interactions between staff and people.

Complaints were logged. Investigations and outcomes of complaints had been documented.

All of the staff told us the service was well managed. Relatives of people gave positive feedback about the registered manager.

There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service. Reports were produced following audits which showed how the service was meeting their own targets and identified business development plans with areas for improvements. These were discussed at management meetings. Although audits were undertaken to assess how standards of care were being met, findings from this inspection identified other areas for improvement.

We found two breaches of the Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Medication administration record (MAR) charts had been completed in full and there were no gaps in the charts that we looked at. There were no PRN protocols in place. Protocols provide guidance for staff administering medicines on when and why people might require additional medicines, and how to recognise when they might be needed. Records of medicine patch applications did not show that manufacturer guidance was followed.

The environment was not always clean. The state of repair of fixtures and fittings meant it was difficult to prevent and control the spread of infection. Infection control audits were unavailable to demonstrate how the service prevented the spread of infection.

Systems in place to ensure air mattresses were set correctly were not robust.

Staff had been trained to recognise and report any signs of harm or abuse.

Risk assessments were in place. Care plans guided staff how to reduce the risks to people.

Is the service effective?

Good

The service was effective.

Staff had been trained to carry out their roles and received regular supervision and appraisals.

People's capacity to consent to their care was assessed. When people lacked capacity, best interest decisions had been documented.

People had access to continuing healthcare. Staff supported people to attend appointments when necessary.

Is the service caring?

Good

The service was caring.

We saw positive interactions between people and staff.

Staff knew how to maintain people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and did not always provide information for staff on people's choices and preferences.

Some aspects of care provision indicated a task focussed approach to care.

Some language used by staff and within care plans lacked professionalism.

Complaints and concerns were reported and investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance audits were undertaken but were not robust enough to identify issues with care planning and delivery.

Staff spoke highly of the registered manager.

People's relatives said they felt the registered manager had a strong, visible presence.

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 took place on 29 and 30 August and was unannounced on the first day. On both days the inspection team consisted of one adult social care inspector. On the first day there was also one 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 other information we held 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. We also looked at information in the 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.

During the inspection we spoke with one person, five visitors, six members of staff, the registered manager and the clinical lead. We received feedback from one health professional following the inspection.

We reviewed four people's care plans. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, staff training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

We looked at medicine administration records (MARs). These had all been signed by nurses to indicate people had received their medicines as prescribed. Some people were prescribed additional medicines, such as pain relief, on an as required (PRN) basis. There were no PRN protocols in place, which we had highlighted during our previous inspection. Having these protocols in place provides guidance for staff on when and why people might require them. Protocols also provide information to staff on how to recognise when people who are unable to communicate, might be in pain. Although two of the care plans we looked at described how people might appear when in pain, not all did. This meant the information was not readily available to staff administering medicines. Additionally, nurses had not always written the reasons for administering PRN medicines or the effectiveness. This meant it was difficult for staff to identify any trends that may require a GP review. The provider's medicines management policy stated, "Any PRN medications must have the rationale behind their use and need a completed administration of PRN medicines plan" and "If it is noticed that a PRN medication is being administered at specific times every day consideration should be given as to whether the medication should be prescribed as an ordinary medication and the consultant, RMO or GP should be consulted." The policy was not being followed by staff because the PRN administration template within the policy was not in use. Also, GP advice had not been sought despite one person's MAR showing they had been given pain relief four times a day for the previous 27 days.

Some people were prescribed transdermal patches. At the previous inspection we recommended the service considered current guidance on recording patch applications. At this inspection we saw staff had written "L" or "R" to indicate which where they had applied the patches. On one occasion a nurse had written "shoulder" but no other entries provided this level of detail. Manufacturer guidance specifies how often patch sites should be rotated, but the system in place did not show this guidance was being followed. For example, one person was prescribed a patch and the manufacturer guidance was "avoid using the same area for at least three weeks." Because of the way staff recorded patch applications they would not know where new patches should be applied.

Some people were prescribed creams and lotions. The MARs had been signed by nurses, despite regularly being applied by care staff. There were no instruction in people's bedrooms to inform care staff when, where or why to apply the creams and no topical administration records in place for care staff to sign to confirm they had been applied. We previously recommended the service consider current guidance for the recording of topical creams; however, this had not been implemented. On the second day of the inspection the registered manager showed us a template they had developed for this purpose which they told us would be introduced.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the main, medicines were stored safely. The medicines trolley was kept in a locked clinical room. The temperature of the room was monitored and records showed temperatures were within recommended limits. The temperature of the medicines fridge was monitored; however, staff had documented the

temperature as one degree centigrade for the previous 28 days. The monitoring chart advised staff the temperature range should be between two and eight degrees. The provider's medicines management policy stated, "When temperatures fall outside this recommended range advice must be sought from the dispensing pharmacy as to whether the medicines are fit for purpose. Any advice given must be acted on and documented for audit purposes." There was nothing documented to indicate staff had noted the temperature was outside of the recommended range or had acted on it. There was another thermometer inside the fridge which showed the temperature as six degrees centigrade; however staff had not used this thermometer to record the temperature. We discussed this with the registered manager who said they would order another fridge thermometer.

Controlled medicines were stored safely. Regular stock checks were undertaken. The process for disposing of unwanted medicines was safe.

Staff said there had been ongoing issues with the pharmacy supply. The registered manager said this was an issue the provider was aware of and was in the process of reviewing.

Relatives of people using the service said they believed their loved one was safe. Comments included, "Yes, 100% safe" and "Basically [person's name] is well looked after."

Staff had been trained to recognise signs of harm and abuse. All of the staff we spoke with knew how to report any concerns. One staff member said, "If I saw any bruises, I'd report it to the nurse." Another said, "I'd report it and document it. Then it would be investigated." Staff were also familiar with the term 'whistleblowing'. All said they were aware of the provider's policy and knew how to report concerns about poor care. One member of staff said, "I would report it to the nurse and go higher if I needed to." Another said, "I'd keep reporting it higher and higher."

Care plans contained risk assessments for areas such as skin integrity, mobility and maintaining safety. When risks were identified, the majority of care plans provided guidance for staff on how to reduce the risk of harm. For example, some people had been assessed as being at risk of pressure sores. Three of the four plans we looked at detailed how often people should be supported to change position and listed any equipment that was in place, such as air mattresses. Position change charts we looked at showed that people had their positions changed in line with care plan guidance. At our previous inspection we found that not all air mattresses were set correctly. At the time there was no process in place to check the mattress settings. At this inspection we saw there was a checking process in place. However, this was not effective because although staff had signed daily to confirm the mattresses were set correctly, 8 of the 9 nine mattresses in use were set for the wrong weight. All of the mattresses were set at 150 kilograms when this was not people's last recorded weight. For example, one person had a last recorded weight of 49.4 kilograms and another person had a last recorded weight of 53.2 kilograms. We informed one of the senior nurses of this and they changed the mattresses to the correct setting. Having incorrect mattress settings can cause discomfort for people lying on them as well as increasing the risk of pressure sores.

Care plans described how staff should move people safely. For example, hoist and sling details were recorded. Some people used specially adapted chairs and in these cases, the plans contained pictures for staff to refer to which showed how people should be positioned safely. Regular checks of wheelchairs and other equipment used to move people safely were carried out.

Incidents and accidents were reported using the provider's centralised electronic record. Records showed how incidents were investigated and the outcome of these. Incidents and accidents were analysed during governance meetings to identify trends.

Personal evacuation plans were in place which documented the support people would need in the event of an evacuation. Fire drills were regularly carried out to ensure the systems were working.

There was enough staff on duty to meet people's needs. Staff were visible throughout the building. Although the service used agency staff, these were block booked in order to provide continuity of care. There was one agency member of staff on duty on both days of our inspection. We spoke with one of them who was able to discuss people's needs with us, which demonstrated they were familiar with the people they were supporting. Staff said they felt there were enough of them on duty. The registered manager told us that staffing levels were based on people's needs. They said, "We have new admissions due next week and so I will increase staffing levels. There is no problem putting more staff on duty." However, one visitor told us when they had asked for their relative to be taken into the garden, they had been told there wasn't enough staff on duty for this to happen.

The provider had procedures in place to ensure staff had checks undertaken before commencing their employment. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Staff had been trained to prevent the spread of infection. Personal protective equipment such as gloves and aprons were readily available. However, some areas of the building would be difficult to keep clean and free of infection because of the condition of the fixtures and fittings. For example, door frames were damaged and chips of wood came loose in our hands when we touched them. The kitchen flooring was not sealed by the door and there was a hole in the flooring by the sink. In some people's bedrooms we saw skirting boards were chipped and had come away from the wall. In one person's bedroom we saw two fall mats that were visibly dirty and one was ripped. The service had one member of domestic staff three times a week for four hours. The registered manager said they had raised concerns about the cleanliness of the environment to the provider and that the service was recruiting more housekeeping staff. They told us infection control audits were carried out monthly by the provider's infection control link person. We asked to see the latest audits during the inspection but they were not available. We asked the registered manager to send us the audits after the inspection, but we were not provided with them.

Good

Is the service effective?

Our findings

Comprehensive pre-assessments were carried out before people moved to the service. The registered manager told us they discussed people who they had assessed with staff in order to ensure they could meet their needs. They said, "If the pre-assessment shows a placement here is not appropriate, then I will say so."

People were cared for by staff that were well trained and supported. Staff spoke highly of the classroom based training they received. Comments included, "If I'm not sure of anything, I ask" and "We do lots of training every year. I've learnt skills that I need in my job, like tracheostomy training and MAPA (management of actual or potential aggression)." Nurses told us they had access to professional development in order to meet their professional registration requirements. One said, "I've had loads of training. I've just finished a management course" and "If you're interested in new things, you can do it [the training]." The registered manager said they were encouraging staff to take on lead roles in an area of their interest. They told us, "I want the carers to develop their skills and knowledge."

Staff had regular individual and team meetings with their line manager to discuss their work, personal development and training. The registered manager kept a record of who was due supervision. This was monitored at regular management meetings. One member of staff told us, "You can bring up anything in supervision meetings. They're really useful." Another said, "I'm due a supervision any day now."

Many people using the service had specialist dietary requirements and received nutrition and hydration via a percutaneous endoscopic gastrostomy tube (PEG). In these instances, care plans detailed the nutritional regimes people needed to receive as recommended by the dietician. People's weights were monitored and when required, advice was sought from nutritional nurses to adjust the regimes. We looked at the care plan for one person who was able to eat and drink by mouth. The plan detailed the position the person needed to be in when eating and drinking in order to reduce the risk of choking. The specialist diet the person needed to have was documented and the instructions for staff when assisting the person were detailed. For example, "Allow time for two swallows per mouthful."

Food and drink monitoring charts had been completed in full and showed people had enough to eat and drink. Fluid charts had daily targets listed and records showed people either met or exceeded these.

People had access to ongoing healthcare. Records showed when people were reviewed by the GP, the dietician, physiotherapist and psychologist. Staff supported people to attend hospital appointments when required. Although people's relatives told us medical support was sought when needed, one person's relative told us they were not always informed when a GP visit was planned. However, other people's relatives said, "Medical care? You can't fault it" and "They always keep us up to date."

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. Consent to care was sought in line with legislation and guidance. When people lacked the capacity to make some decisions about their care and support needs, mental capacity assessments had been carried out and there was documentation in place to show how best interest decisions had been reached. Staff told us they offered people choices. One said, "We ask people, although they might not always be able to respond verbally." We saw staff offering people choices, such as, "Would you like to sit here?" and "Would you like me to switch that on for you?" One person told us they didn't like it when staff made them stop what they were doing. They said, "They [staff] keep telling me it's for my own good and that I need to rest." They said although they knew it was for their own good, they didn't like being told what to do.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager maintained a log of DoLS applications and authorisation and had notified us of all approved applications.

The environment was not consistently homely. In the communal lounge we saw a linen trolley and there were piles of clean clothes waiting to be put away. A curtain rail was propped up against one wall. In the conservatory, chairs and other items were being stored which meant the space was not welcoming. Wallpaper was torn in some areas, walls and doors were badly scuffed and chipped. The carpet by the front door was visibly stained. One relative told us the lift was "not fit for purpose." A member of staff told us, "The lift isn't big enough. Some of the wheelchairs are a tight squeeze; one person's feet are pushed up against the glass. I've raised it, but nothing happens." Overall the building was 'tired' and in need of refurbishment. We raised this at the previous inspection and were advised at the time that a refurbishment plan was underway; however, this work had not begun. We saw this issue had been logged in the quality improvement plan as far back as October 2016. The registered manager confirmed environment issues were raised monthly and had been reported to the maintenance team and to the provider. Staff told us, "This place is a bit shabby generally" and "As a team we try to make it feel welcoming and homely."

Good

Is the service caring?

Our findings

The majority of people were unable to verbally express to us their experience of living at the service. One person told us, "I like the permanent staff." Comments from people's relatives included, "The staff are very attentive and respectful all the time" and "The staff are wonderful." However, one relative told us, "I don't feel all the staff are caring. It's like it's just a job to them" and "There are a couple of really good ones. The new staff are all very professional."

We observed some positive interactions between staff and people. For example, we saw one member of staff walk into the lounge and say to one person, "Hello [person's name]. You're looking very dapper today." They then approached another person and said, "Good morning [person's name]. How are you today?"

During the inspection one person's relative contacted the service to ask if the person could go home for a few hours as an old friend of theirs was visiting. The manager and senior nurse discussed how to make this work and the home visit was arranged at short notice.

Staff spoke highly of their roles. Comments included, "Personally I do think the care is good. Staff take pride in what they do here" and "I enjoy my job. Care is good here. We look after people as we would like to be looked after." One member of staff said, "Care is good. It's like one big family here."

The registered manager told us all staff were 'dignity champions'. Staff told us they knew how to maintain people's privacy and dignity. One said, "We always give personal care in people's rooms, close curtains, shut the door. If I notice someone's clothes are dirty, I'll change them." However, one relative said, "A few weeks ago, [person's name] didn't smell clean." They told us the person liked to use deodorant and wear aftershave but they didn't think staff had used it. The registered manager told us they had recently received a concern from a relative about a lack of nail care. They said they now checked people's nails themselves and had implemented "manicure days" to promote good nail care.

We observed staff knocking on people's bedroom doors prior to entering. They introduced themselves and told people what they were doing. One member of staff said, "I always go round to see people first thing. I say hello, tell them the day and the date and remind them where they are."

People's spiritual needs were met. Care plans detailed how staff should achieve this. For example, it was written in one person's plan, "Enjoys Christian music and having the bible with [them]."

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 15 June 2017 we found improvements were required because care plans were not person centred and lacked details of people's preferences for how they wanted their care to be provided. People's life histories were not included in care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, however not all of the plans we looked at contained this information.

We looked at four care plans. Two of these provided detailed information for staff on how to support people based on their personal needs and preferences. For example, in one person's plan there was detailed information in relation to how the person should be supported to move, and how they wanted to participate in this as much as possible. The same plan detailed things that might cause the person to become agitated and frustrated. There was clear guidance for staff on how to recognise when the person felt this way and how staff should support them. The two other plans did not contain the same level of detail. We were told this was because for some people this information was not available; either because people couldn't tell staff their preferences and/or because there was limited family involvement to inform staff. Where the information was available, it was included within the care plans.

Several people had difficulties communicating. Communication plans were also varied in the quality of information they provided. One plan detailed how the person communicated using electronic aids. We saw a member of staff using the equipment with the person in order to communicate with them. However, another person's plan guided staff to, "Use my body language to try and ascertain whether I need assistance." There was no information for staff on the body language they should be observing for. Another person's plan guided staff not to discuss events the person might find distressing, but did not detail examples of these.

One of the four plans detailed people's preferences in relation to how they wanted to be supported with personal care. Although three of the plans provided some information, they did not detail the person's choice of clothing or whether they wanted to be supported by a male or female member of staff.

Care staff we spoke with were not familiar with the term 'person centred.' One member of staff said, "No, I've not heard of that." Another said, "It's focussing on the client and doing what's best for them." Staff told us that night staff "helped out" by washing two people each morning before day staff arrived on duty. None of the staff knew how people who were unable to communicate had agreed to be washed in the early morning. There was a 'bath and shower' chart which was pre-printed and specified the days on which people were to have a bath or shower. The charts had been signed by staff to indicate this had happened. Records showed people always had a bath or shower on their designated day and there was nothing documented to indicate that people had been offered showers or baths on any other days. In one person's care plan it was documented, "I am to have a bath 2-3 times per week minimum." However, the charts showed this person had a bath once a week. These examples indicated a task focussed approach by staff rather than a person centred one.

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

Some of the language used in documentation was unprofessional. For example, in one care plan it was written, "I am to be turned at least every four hours." The use of the phrase "turned" also indicated a task approach to care and support. One member of staff we spoke with referred to people who required assistance to eat and drink as "feeders." This indicated a lack of professionalism and a lack of respect.

Plans in relation to people's health needs were detailed. For example, tracheostomy care plans and catheter care plans guided staff on how to manage these aspects of people's care.

Relatives told us they were invited to attend care plan reviews. One said, "Yes, we went through the plan with a nurse recently." Another said, "We've got a review coming up soon."

There was a copy of the complaints policy available in a public area and people's relatives told us they knew how to make a complaint. One relative said, "If I have any concerns I tell [manager's name] and [they're] on it immediately." Another said, "I had to make a complaint once, but it was dealt with." We saw the complaints log which showed that all concerns were logged and investigated. The outcome of complaints was documented. The registered manager told us, "All the families have my email address and phone number, and it seems to work well. They can raise any complaints to me directly." They explained how lessons learnt from complaints were shared with staff. They said, "I aim to resolve any issues immediately when I can. And then I will keep looking and checking that the problem has been sorted. We had a complaint that people had limited community trips and we now plan trips a month in advance so that people can get out, go places or meet up with their families."

There was an activities co-coordinator in post. They told us they spoke with people's families to understand about people's interests so that they could focus activities on things people would enjoy. They said, "I vary the activities. Some people are able to use their hands so I run a craft group for them and we make cards. Other people are religious so I will read the bible to them, one to one or in a group." They said they organised trips out for people, although these needed to be planned in advance because of the need to have a nurse present. External entertainers visited and performed pantomimes and musically themed shows for people. A garden party had been held some weeks prior to the inspection. Several staff mentioned this to us. They said people's relatives came and staff attended with their families. Relatives gave mixed feedback about whether there were enough meaningful activities for people to take part in. One said, "The activities staff are great. [Person's name] does finger painting with them." However, another relative said, "It's always the same people that get to go out on trips."

Requires Improvement

Is the service well-led?

Our findings

There were quality insurance processes in place. This included monthly reviews of key performance indicators such as incidents, training and supervision and status of DoLS applications. Audit summary analysis was undertaken in areas such as medicines management, documentation, care plan reviews and health monitoring. However, although audits were undertaken they were not robust enough and did not always identify the issues we noted during the inspection. For example, care plan reviews did not identify the lack of consistently person centred planning. Medicine management audits did not identify the lack of PRN protocols, or that manufacturer guidance in relation to transdermal patch rotation was not being followed. The staff emphasis on task focussed care rather than person centred care had also not been identified as an issue.

We were not provided with copies of any infection control audits despite requesting them. Quality improvement plans showed that issues in relation to the upkeep of the environment had been raised as far back as 2016 but had not been completed. Regulation 12 requires providers to prevent and control the spread of infection. The Department of Health issued The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance, a Code of Practice about the prevention and control of healthcare associated infections which CQC must take into account when making decisions. In section 1.5 of the Code under Assurance framework states; "Activities to demonstrate that infection prevention and control are an integral part of quality assurance should include an audit programme to ensure that appropriate policies have been developed and implemented". Section 1.7 also states "The infection and prevention and control programme should set objectives that meet the needs of the organisation and ensure the safety of service users." This meant the provider could not be certain of the progress made with meeting set standards.

The registered manager was relatively new in post. They were aware of some of the shortfalls we identified. They told us they had begun to make improvements to the service such as implementing documentation for staff to sign when putting splints on people, compiling a safeguarding file so that staff could access information quickly and putting in place 'dignity champions'. They told us they had started to engage care staff to be involved in care planning and said, "There is now a template for carers to fill in with people's likes and dislikes so that nurses can use that information for care plans."

Staff said although regular meetings were meant to take place, they didn't always happen. The latest available staff meeting minutes were dated May 2018 and July 2018. The registered manager said more meetings had taken place, but they were unable to locate the minutes of these. The minutes of the latest meeting reflected the improvement plans the registered manager had discussed with us.

Staff spoke highly of the registered manager. One member of staff said, "[Manager's name] is very good and reliable. [They] get on well with everyone and we've got quite a lot of support." Another said, "[Manager's name] is very nice. [They] work very hard and have got the right approach. [They] won't take any rubbish." One other staff member said, "[Manager's name] is visible, knows all our service users and relatives by name. [They] have a presence and understand because they've seen it first-hand. It's nice knowing if you have a

concern, [they] will back you." The registered manager said, "Staff will now think about things and say, "Can we do x or, this needs to be changed. It feels like better teamwork."

Relatives we spoke with said, "Since the change of management everything is improving. Unfortunately, it will take time, but I think they [staff] underestimate [manager's name]."

Despite staff speaking highly of the registered manager, not all of the staff we spoke with said they felt valued by the provider. One member of staff said, "It's not as if we don't like change, but the new owner does things their way. I've never met [provider's name]; as far as I know [they've] never been to this building. It would be nice for them to pop in and say hello." Another said, "Lots of managers wander round here, but I don't know who they are. [Provider's name] hasn't even been here. We were told nothing would change, but a lot has." Two members of staff said, "I'm just a tiny cog in a big wheel." One member of staff said, "I feel valued, definitely. We had a meeting recently and we were told how valued we were."

The registered manager said they were well supported by the senior management team. This included weekly meetings with the clinical lead, the operations manager and managers from the provider's other services. They said they also felt supported by the ward sisters and senior nurses. They said, "Ward sisters and senior nurses all say they're more involved than ever before."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not always provide information for staff on people's choices and preferences. Some aspects of care provision indicated a task focussed approach to care. Regulation 9(3) (b)-(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no PRN protocols in place. Records of medicine patch applications did not show that manufacturer guidance was followed. Systems in place to ensure air mattresses were set correctly were not robust. Regulation 12(f) & (g).