Hamsard 3232 Limited

Woodlands Neurological Rehabilitation

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 17 and 18 February 2016.

The last inspection took place on 22 April 2015. At that inspection we asked the registered provider to take action to make improvements to Regulation 12: Safe care and treatment. This action has now been completed. After the comprehensive inspection on 22 April 2015 the registered provider wrote to us to say what they would do to meet the legal requirement in relation to the breach of regulation.

Woodlands Neurological Rehabilitation Centre provides treatment, rehabilitation and care to people with a range of neurological conditions such as Epilepsy, Multiple Sclerosis, Brain Tumours, Parkinson's Disease, Stroke, Traumatic Brain injuries and other neurological issues such as spinal injuries. The service provides a transitional ventilated unit to care for those who are ventilator dependent and a transitional living unit for people with physical, cognitive and functional needs.

The service was a two storey building, with the upper floor being used as staff areas and a two bedroom flat used by more independent service users, that was not in use at the time of our inspection. The ground floor had 24 bedrooms, four on the Transitional Ventilated Unit (TVU) and 20 in the main unit all fitted with en-suite bathrooms. The main unit was split into the East and West Wing areas; the East Wing had ten bedrooms, a kitchen area, dining room and conference/training room and the West Wing had 10 bedrooms, and the TVU led off from these. The main unit also had a central section that contained the administration and reception facilities, a lounge and conservatory area and a gym. The central section also held a large facility used by the multi-disciplinary team as an office and work space. We found there was a total of 17 people using the service when we inspected.

The registered provider is required to have a registered manager in post and there was a manager who had registered with the Commission and had been in post since July 2015. 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 told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following robust recruitment and selection processes.

Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. Sufficient permanent staff had been recruited since our last inspection to ensure the use of agency staff was reduced from previous levels. Staff did not appear rushed on the two days of our inspection and there was a good atmosphere in the service.

Improvements had been made to the medicine practices in the service. Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

Robust infection control practices were being used in the service and risks to people were being monitored and reviewed on a regular basis.

The registered provider had an induction and training programme in place and staff were receiving regular supervision. People were confident in the staff skills and knowledge and said the reduction in agency staff meant they were receiving better care and support.

We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plenty of drinks throughout the day.

People had access to a limited range of social activities and events within the service. Some people said they were bored and action was being taken by the registered manager to improve this aspect of the service.

People were included in decisions about their care and we saw that appropriate care and support was being offered to people who used the service. We observed a number of positive interactions between the staff and people they were caring for. People received a detailed assessment to determine if the service was right for them. Assessments were person centred and included input from a range of professionals.

People were treated with respect and dignity by the staff. There was a formal complaints system in place to manage complaints if or when they were received.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the changes taking place in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults' procedures.

Staff had been employed following robust recruitment and selection processes. Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. There were robust control and prevention of infections systems within the service and we found the service to be clean and hygienic.

Improvements had been made to the medicine practices in the service. Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plenty of drinks throughout the day. People reported that care was effective and they received appropriate support from a team of specialists and healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience when supporting people. Clear explanations were given to people as tasks were carried out by the staff. This meant people understood what was happening when receiving assistance and support.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive.

We found that people received the care and support they required to maintain their health and wellbeing. Staff were able to tell us about people's care needs and demonstrated a good knowledge of their health care conditions.

People had access to a limited range of social activities and events within the service. Some people said they were bored and action was being taken by the manager to improve this aspect of the service.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well led.

People were at the heart of the service, which staff continually strived to improve. People who used the service said they could chat to the registered manager and relatives said the registered manager was understanding and knowledgeable.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

Staff were supported by their registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the registered manager.

Woodlands Neurological Rehabilitation

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 17 and 18 February 2016 and was unannounced. The inspection team consisted of one adult social care inspector and two specialist advisors. A specialist advisor is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. The specialist advisors had knowledge and experience relating to physiotherapy, people dependent on ventilated support, occupational therapy and people living with neurological conditions.

As part of the inspection process we contacted the local authority safeguarding adults and commissioning teams to enquire about any recent involvement they had with the service. We were notified of some concerns raised by the Clinical Commissioning Group (CCG) around the number of people on ventilated support who were accepted as patients at Woodlands and who then were subsequently admitted to York District Hospital.

At this inspection we spoke with the registered manager, deputy manager and the human resources and training administrator. We also spoke with ten staff members and spoke in private with three visitors and four people who used the service. We carried out observations on both the Transitional Ventilated Unit (TVU) and on East Wing and West Wing of the main unit. We observed the lunchtime experience of people in their bedrooms and in the dining room.

We spent time in the office looking at records, which included the care records for five people who used the service, the recruitment, induction, training and supervision records for four members of staff and other

records relating to the management of the service.

Good

Is the service safe?

Our findings

At our last inspection in April 2015 we found that there was unsafe medicine management. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 17 and 18 February 2016 we found that the registered provider had followed the action plan they had written following the April 2015 inspection and sufficient improvement had taken place to evidence that the breach had been met.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. People we spoke with said their medicines were administered on time and were always available when needed.

On the Transitional Ventilated Unit (TVU) all medicines were kept in people's own rooms in locked cupboards. The qualified nurse was the designated person who had overall responsibility for the medicines and the medicine policy and procedure was accessible to the staff and included best practice guidelines. The nurse communicated effectively with people, even those unable to say if they were in pain or were in need of support. The nurse told us, "We know the people who use the service. We look at their posture, their facial expressions and the majority of people can use gestures to let us know how they are feeling." Staff had received medicine training and we saw evidence of up to date competency checks on staff practice. There were no controlled drugs on the TVU, but a register and cupboard were available should the need arise. Checks of the controlled drugs on the main unit found these to be appropriately stored and recorded. Controlled drugs are those medicines required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

On the main unit we found that the medicine room and fridge temperatures were taken twice a day and on occasion they had come close to the maximum recommended room temperature of 25 degrees centigrade. The registered manager told us that the registered provider was looking at different ways to cool the room down especially in the summer months.

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service. Comments included, "All the staff are lovely" and, "I feel safe here." Staff told us they thought people were safe and they had no current concerns about safety.

Discussion with people that used the service and staff revealed that people had diverse needs in respect of one of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against in the service. People were enabled and encouraged in many ways to regain their independence and their rights were respected by the staff on duty.

We found that the service had systems in place to manage safeguarding incidents and there was evidence in staff training records that staff were trained in safeguarding of adults from abuse. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents. The registered provider had policies and procedures in place to guide staff in safeguarding adults from abuse. We spoke with staff about their understanding of safeguarding. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse.

There had been 13 instances in the last year when the safeguarding alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. The local council safeguarding team were sent the correct information and where necessary an investigation had been completed. Information we received from the local council before the inspection indicated there were three on-going investigations. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. We observed that the hydro-therapy pool was kept locked (when we were shown around the unit) and it was explained that this was a safety measure.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. Staff carried out a series of safety checks for people on the TVU including chest checks looking at the ventilator, tracheostomy and noting any changes. Staff also completed cough assessments. Each person was assigned two health care assistants each day and overall the unit had five to six staff on duty during the day and three to four staff at night. This ensured people had enough staff to meet their needs and keep them safe through the provision of good care and regular assessment of risk.

We had received some complaints and concerns from health care professionals and families about the level of staffing in the service over the last year. Care staff said there had been an increase of bank and agency staff use over the last year for both nurses and health care assistants and this had impacted on people's care. We noted that the supervision process had recorded that issues around staffing, communication issues with nurses, staff working long shifts and agency workers not being tracheostomy trained had been raised with the management team. The registered manager told us that these concerns had been listened to and on-going recruitment was in place. The registered manager had just recruited five new health care assistants to work across the TVU. The improvements to staffing had been noted by the relatives we spoke with and one told us, "The constant changing of staff does not help [Name], but over the last few months this has really improved. Less agency staff are being used and better communication with families is now taking place."

The lead professional said there were sufficient numbers of staff on TVU. We were told there were no issues with short staffing and that there was usually a lead professional or a nurse in charge and three competent health care assistants on the unit. No agency staff had been used recently and a new lead practitioner for the unit was due to start imminently. We spent time observing daily life on all units and we found that staff did not appear rushed on the two days of our inspection and there was a good atmosphere in the service.

However, at the time of our inspection there were some agency staff being used within the service, but we were advised by the registered manager that they were using regular staff who knew the people well.

On the main unit the staff team comprised of one nurse, one senior rehabilitation assistant and two rehabilitation assistants on each wing each day. The Multi-disciplinary Team (MDT) comprised of a consultant psychologist and their assistant, two physiotherapists (and the service was recruiting for a third) and two speech and language therapists – one was the main MDT lead. There were also two occupational therapists (and the service was recruiting for two more).

We spoke with staff during our inspection and they all said the staffing levels were much better. One member of staff said, "There is less agency staff now and that is a good thing. The standards of care being given are higher and we are responding to people's needs much quicker. The whole atmosphere in the service has changed and staff morale has risen." Another member of staff told us, "It remains very busy, but we are working better as a team." A new method of team working started February 2016 and although some staff were wary of how this would change the working practices within the service, other staff felt it would improve things.

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs.

We saw that the service had maintenance safety certificates in place for utilities and equipment used in the service and these were all up-to-date. There were contracts of maintenance in place for ensuring the premises and equipment were safe at all times. These safety measures and checks meant that people were kept safe from the risks of harm or injury. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights and bed rails. These environmental checks helped to ensure the safety of people who used the service.

The registered manager spoke to us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. We also saw people's personal safety documentation for evacuating them individually from the building in the event of a fire. There was a 'grab pack' in the administration office for staff to use during any fire emergency. This included equipment and directions for the designated fire marshal. There were signing in books on the reception for visitors and staff used an electronic clocking in and out system so there was a record of who was in the building should an emergency occur and evacuation be needed.

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

The staff we spoke with had good knowledge of infection control including use of personal protective equipment or PPE (aprons and gloves). Appropriate clinical protocols were being followed on the TVU with regard to the people who received ventilated support and staff received support from specialist respiratory practitioners. We saw that care staff completed check lists to ensure sterile water was changed every 24 hours, suction equipment was cleaned after use, wound sites were cleaned daily and syringes were changed daily. Tracheostomy checks were completed every half an hour, when the inner cannula was cleaned and once a day the dressings were renewed. Infection control audits were carried out yearly and the last one dated November 2015 scored as 88 percent compliant and had an action plan for the outcomes noted as needing improvement. These had been signed off by the registered manager when completed.

The units were clean, well lit, spacious and free from clutter. On the TVU each room was fitted with a ceiling hoist, these were cleaned after each use and also weekly. Discussion with the domestic staff showed they had policies and procedures they followed with regard to infection control, including colour coded mops, buckets and cleaning clothes for different areas of the service. We saw them deep cleaning one of the bedrooms on the TVU and this included moving furniture and washing down the walls. Cleaning schedules were in place and completed daily. Those seen were up to date.

All areas we looked at, including the sluice rooms and bathing facilities were clean, tidy and there were no unpleasant odours around the service.

Good

Is the service effective?

Our findings

People and their relatives reported that the service provided effective care overall. People said they felt the staff were supportive, well trained and gave them good support. One relative told us, "The staff know [Name] well what they like and how to look after them."

The registered provider had a list of mandatory training sessions and more specialist training that they required all staff to complete according to their role within the service. The mandatory training was supplied by the registered provider's in-house e-learning system, but there were also external trainers who delivered face-to-face training.

We looked at induction and training records for four members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the home. We also spoke with staff about their experience of the induction training and on-going training sessions.

Staff confirmed they completed an initial classroom based induction which orientated them to the service and covered corporate information such as employment issues, policies and procedures and layout of the building. Each new member of staff then went on to complete an induction based on the Care Certificate from Skills for Care. Skills for Care is a nationally recognised training resource. We saw that new staff were allocated a mentor and the documentation we looked at indicated new staff shadowed more senior staff and the MDT for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

The registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed.

Staff received direct supervision from their line manager. Supervisions from November 2015 had been carried out every two months; the registered manager said they had tried to ensure all staff had a least one session and that this was improving. We spoke with the registered manager about how issues were picked up and addressed if they did not personally do the supervisions. We were told that there was a matrix on-line that captured worries or training needs. There had been a series of workshops and meetings held as a result of feedback from staff. Staff appraisals were carried out annually. We were given access to this documentation during the inspection.

People on the TVU received Ventilated support and care from the multi-disciplinary team (MDT) comprised of physiotherapists, occupational therapists, nurses and health care assistants. Also on-site were other specialist practitioners such as Neuropsychologists, Occupational Therapists, Neurophysiotherapists and the Speech and Language Therapists (SALT). At the time of our inspection there were two people on the TVU. The registered provider (Christchurch Group) had their own set of consultants who visited the service every Friday and reviewed all the people as needed. They made recommendations and these were followed

up by the local GP's as they remained ultimately responsible for the people in the service. The consultants provided specialist input to people such as administration of Botox. Care plans were updated by the therapy team. Any concerns were documented. Issues with people's diet were raised with the SALT and the hospital team.

Staff administered nutrition to some people using a percutaneous endoscopic gastrostomy (PEG) feeding tube. A PEG is a procedure that takes place for a person who cannot take nutrition orally. A tube is inserted through the person's abdominal wall and into the stomach, through which nutritional fluids can be infused. The staff also gave people on the TVU nebuliser therapy and deep suction as needed. People were showered or bed bathed daily according to their care needs. People were given passive stretch exercises daily and hydro therapy as needed. Best practice guidance was disseminated from the lead professionals and hospital link people down to the health care assistants. The service was an approved provider (2015-2017) for Headway, regarding accredited provision of brain injury care.

The registered provider employed Specialist Respiratory Nurses who updated all the staff training with regard to Tracheostomy and Ventilators; they followed the Royal Marsden guidelines. These nurses were responsible for signing off the lead professionals competencies.

We saw evidence of competency documents for the health care assistants regarding the people on ventilated support. These covered tracheostomy skills such as changing the inner tube, changing the dressing and use of suction. Staff skills on carrying out cough assessments and long term tracheostomy changes were also checked and reviewed. The competency checks covered staff skills with regard to PEG tubes including care of the PEG site and administering the daily fluids and feed regime. All the capabilities were detailed, in depth and ensured staff delivered safe, effective care to people who used the service. These competencies were signed off by the direct senior of the member of staff. Staff told us that the lead practitioners trained other staff with a mix of theory and practical sessions. Staff competency was then checked on a regular basis and recorded in a format of watch, assist and do.

The Physiotherapists and Occupational Therapists had well equipped dedicated areas to work within. The therapists had a shared office facility which promoted good inter-professional working. All the staff interviewed said that the different professions worked well together. There was evidence in the care files that information was being shared between the different professions involved with people using the service. Therapists' files were kept within the nursing station to allow ease of access, and therapists also wrote notes within the nurse files. The staff were using well established measures to monitor client progress such as Goal Attainment Scaling (GAS), Functional Independence Measure and Functional Assessment Measure (FIM / FAM). This meant staff established a baseline of needs for each person and then looked at their progress. The therapy team wrote out action plans for the person and care staff to follow and their progress was reviewed every three months.

Discussion with the therapy team lead indicated that the service also used The UK specialist Rehabilitation Outcomes Collaborative (UKROC) to record information gathered during people's care. UKROC was set up through the Department of Health in 2008 to develop a national database for collating case episodes for inpatient rehabilitation. In the first five years it focused on neurorehabilitation and ultimately its goal is to include data from all specialist Level 1 and 2 neurorehabilitation services, across the UK. The MDT completed an assessment of each person every 12 weeks looking at activities of daily living and rehabilitation progress with each part of the team inputting to the assessment and giving the person a score. These assessments were used as part of the three monthly reviews with the families, person using the service and the commissioners.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. Records showed that five people who used the service had a DoLS in place. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

There was evidence in the care files that the mental capacity of people was being considered when there were concerns about someone lacking capacity to make a particular decision. A member of staff explained how they had been able to witness the Clinical Psychologist doing a mental capacity assessment. Another member of staff explained that one person, lacking in mental capacity to agree to their post-discharge care arrangements, had had their discharge delayed because the arrangements (made by their family) were not considered to be safe or in their best interests. We observed documentation in their care file which confirmed this.

Staff showed awareness of people's rights and MCA. In discussions staff were clear about how they gained consent prior to delivering care and treatment. For example, one member of staff knew to ask people for consent before giving care, but was also aware there were people who were cognitively impaired so followed their care plans, which were all individual and detailed about the support people needed.

During their supervision one member of staff had raised concerns about how to manage people who hit out when receiving personal care. We saw that the registered manager had emailed straight away to an employee who specialised in challenging behaviour training and consulted with a clinical neuropsychologist to discuss what type of training would be the most effective for the staff group and the people who used the service. Work was in progress to deliver a bespoke training package to all staff that took into account the specialist needs of the people who used the service, whilst using best practices and minimal restraint techniques. We saw that a best interest meeting was held for one person to discuss their behaviours and a DoLS application had been made following the meeting.

We discussed the menus with the chef. Breakfast was served between 08:00 and 10:30 and was a continental style option Monday to Friday. On a weekend there was a cooked breakfast option. Lunch was served at 12:30 and dinner at 17:30. Each day there was a meat or vegetarian option available and there were hot and cold dish choices both at lunch and dinner time. Alternative meal choices included baked potatoes, salads, omelette, sandwiches, cottage pie, ice-cream, sorbet, yoghurt or cheese and biscuits. A menu board was on display in the dining room. Most people had capacity to make their own choices and options were available if they changed their minds.

The menus we saw highlighted what meals were suitable for diabetics and vegetarians. A lighter meal was served at lunch time due to the number of people taking part in rehabilitation treatments soon after. The evening meal was more substantial and included cakes and pudding options. People made their choices around meals on a daily basis and these were recorded on a sheet. The menus operated on a three week

cycle, which was also seasonal. People were able to input to the menus through the use of comment cards and the chef met new people when they first came into the service to discuss their dietary needs. This was confirmed by one person who explained that they were a 'picky eater,' but that they had been able to meet with the head chef who had agreed a range of foods/meals that would meet their food preferences.

The chef showed us the list of soft or pureed diets that was kept in the kitchen and they spoke confidently about the use of different textures in making food palatable and the use of moulds to shape soft foods into attractive shapes. We also discussed the making of meals suitable for diabetics and those with swallowing difficulties. All meals prepared in the service were made from fresh ingredients.

People had access to specialist cutlery, plates, feeding beakers and non-slip mats to assist them in eating and drinking independently. During the lunchtime period we observed one person struggling to eat their dinner. This was noticed by a member of staff who provided alternative cutlery to assist them. People were also able to prepare their own meals in the MDT kitchen as part of their therapy programme to improve their daily living skills.

Good

Is the service caring?

Our findings

We observed that there were good interactions between the staff and people who lived at the service, with friendly and supportive care practices being used to assist people in their daily lives. Calls for assistance were answered in a timely manner and staff were visible in and around the service and were seen attending to people's needs. One person told us, "The staff are caring and helpful" and three visitors said, "The staff have been polite, helpful and respectful." All of the staff who we interviewed reported that their colleagues were caring and compassionate.

We observed that staff displayed kindness and empathy towards people who lived in the service. Staff spoke to people using their first names and people were not excluded from conversations. We saw that staff took time to explain to people what was happening when they carried out care tasks and daily routines within the service. One person told us, "The staff are good and caring here." Care plans were person specific and people were given choice about what they wanted to do and when. The service had introduced a 'This is me' booklet in people's care files to document people's preferences and likes/dislikes. We looked at a number of these as part of our review of the care files.

Staff told us that care plans covered dignity, privacy and respect. Each person had their own room with washing and bathing facilities. In discussions, staff had a good understanding of how to promote privacy, dignity, choice and independence. They said, "We close doors and curtains and gain consent for tasks. We always knock before going into a person's room or bathroom as a number of people like some privacy at times. Everyone has different preferences and routines, so it is important we listen to what they want from us and ensure they have the opportunity to make their own choices." This was confirmed by one person who used the service. They told us, "I get time to spend by myself; staff always knock on my door and wait for permission to come in."

The registered provider had a policy and procedures for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in their care files. People were supported to maintain their spiritual, religious and cultural needs if this was what they wished to do. We saw that where people expressed a preference for female or male staff supporting them with their personal care, this was respected by the staff and documented in their care file.

We spoke with one relative whose family member was living with a brain injury; they gave us many positive comments about the service. They told their family member had gone through two or three really bad episodes of illness and had good and bad days now. Their family member had limited communication depending on the day. The relative told us, "I chose Woodlands due to their facilities. I feel the staff are friendly, helpful and caring. [Name] is treated as a human being here and staff give [Name] respect and honour their wishes. [Name] is maintaining their health and wellbeing. The staff are constantly trying new things with care and rehabilitation, they maintain [Name's] physical needs and ensure they wear their splints, use their wheelchair and carry out positioning and passive stretching."

Unlike most care homes this service operated much like a hospital setting in that there were set visiting times Monday to Friday 18:00 to 20:00 and Saturday to Sunday 11:00 to 20:00. These depended on each person's rehabilitation plans developed by the MDT. The registered manager explained that the limited visiting hours gave people time to complete their treatment and have rest periods without interruption from visitors.

Advocacy information was on display in the entrance foyer with details of the Independent Mental Capacity Advocate (IMCA) service and leaflets. There was also a display rack of information on disabilities such as Alzheimers and brain injury.

Staff told us they enjoyed working in the home. They said they had a good range of equipment to help them meet people's needs including specialist beds and mattresses, hoists and slings and bed safety rails. They said that the environment was safe and secure. One member of staff told us, "I like it here, it is nice and the people I look after are lovely." A therapist reported that they had the equipment to meet most of the rehabilitation needs of people using the service and that they were hopeful of management agreeing to purchase a more specialist item that they had requested.

People had detailed care files. Their past medical history was recorded and in care files on the TVU, ventilator settings prescribed by the hospital were documented. Care plans we looked at were up to date and reviewed monthly. Two people whose care we looked at in detail were comfortable and there had been no change in their physical condition, no contractures of limbs and they were able to sit out daily. They had been seen by SALT and their nutritional and hydration needs were reviewed the previous week; a change of diet had been recommended and was actioned by the staff.

A notice in the unit's reception area asked visitors, for reasons concerning data protection and confidentiality, not to get involved in the care of other people using the service. However, we saw that confidential care planning information (Red file) was left in the corridor leading to people's bedrooms. The registered manager was informed about this and took action to ensure the information was stored appropriately.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs. The care files we looked at were written in a person centred way. Essential daily care planning information was kept in a file (Red file) held close to each person's room.

The therapy lead told us that all referrals to the service were taken to the MDT meeting each Friday and discussed. An initial assessment was carried out by a therapist and a nurse and the person's medical notes were reviewed. Then a meeting with the person and their family was set up to talk about their needs and expectations of the service, to ensure realistic goals were set and clearly understood. The registered manager told us that this was an area of assessment that the team needed to improve on and work was on-going to learn from past mistakes. One person and their relatives told us how members of the MDT had visited them at home and done a pre-admission visit to do an assessment of their needs and explain what the unit had to offer.

A member of staff was able to describe the usual 'Care Pathway' that each newly admitted person followed and the assessments that would be used. This would entail using, after six weeks, the Canadian Occupational Performance Measure (COPM), to agree person centred outcomes. One person using the service was able to describe the goals that their therapists were working towards with them. All of the people were provided with weekly printed timetables, kept in their rooms, to inform them about their weekly activities/therapy sessions.

There was evidence in the care files that review meetings were held that involved the service users and their relatives. A therapist reported that commissioners regularly attended review meetings and wanted to know how people were progressing. The therapy lead told us, "We use the UKROC information to gather a baseline of needs and we also use this as a costing tool. We write a report and discuss this again at the MDT meeting and recommendations are put onto the report, which is then sent to the commissioners who made the referral."

We were told that on arrival people had a four week assessment period. The first week the MDT met with the family and person and discussed expectations, knowledge of their conditions and set goals using the GAS tool. Each week the MDT held two meetings with staff to discuss the progress being made. Every two weeks further assessments were carried out and these fed into the review process. Three monthly reviews were held with the commissioners, family and person using the service and these were the decision times for further funding.

Discussions with the registered manager, MDT members and staff indicated that they were all enthusiastic about moving the service forward using best practice to improve the experience of people using the service. For example staff explained how they had devised a way of moving one person and assisting with their personal care to reduce their tendency to lash out at anyone who was trying to support them. Staff also told us that the number of Occupational Therapists had been increased in order to better meet the needs of

people using the service. The staff rota system had been revised to ensure staff teams were more consistent and people experienced fewer staff changes. Members of staff described how the new staffing arrangements enabled three rehabilitation assistants to be available to support the therapeutic activities.

People told us they were bored as they did not receive enough stimulation. There were daily therapeutic activities taking place, but when these were completed then people had time on their hands and little to do. This had been recognised by the registered manager who told us the clinical basis of the service meant it had not placed much emphasis on social interactions in the past. However, discussions were taking place looking at how this aspect of care could be improved. At the moment activities in the service were low key with one person coming in on a Tuesday and a Thursday to do activity sessions with people.

A pastoral care group visited the service each month and offered people spiritual support. Staff also were prepared to take people to local churches as required. The service had a vehicle, which was wheelchair adapted and staff were trained to drive this. It was used for going to appointments and social trips out to the shopping centre, visits to families and horse riding. People had access to the hydrotherapy pool and took part in life skill sessions in the occupational therapy kitchen. We saw that people were sat in the lounge and conservatory areas reading newspapers and magazines that were delivered to the service. People had access to a selection of books and DVD's within the service.

People in the service were assessed by the Occupational Therapists and where needed specialist equipment was provided to make their lives easier. One person told us how they liked to do research about their own condition and passed information to staff for them to consider, which the person said they did, for example, in relation to some new splints. Two people had 'possum systems' and one person had an IPad and eye gaze system in place (different types of electronic aids for operating equipment and for communicating). The registered manager told us there was a small IT suite for people to use and it was planned for this to be refurbished in 2016.

People and relatives knew how to make a complaint and the registered manager listened to these and took appropriate action to improve practice within the service. We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. One person explained how they had complained to the registered manager about the attitude of a member of staff, and that this had been dealt with in a way that resolved their concern. Another person said that they did not think that they had been receiving enough stretches for their contracted limbs, but that their concerns had been listened to and the matter was now resolved. We spoke with one person who had written to us about a number of concerns. We were pleased to hear that they were happy with their care and they told us, "The manager dealt with my issues and things have improved." This indicated that the service was responsive to people's needs.

Good

Is the service well-led?

Our findings

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and sought ideas and suggestions on how care and practice could be improved. Staff told us they had confidence in their colleagues and there was visual evidence of good day-to-day teamwork.

There was a registered manager in post who was supported by a deputy manager and the MDT. The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People who spoke with us all knew and claimed they got on well with the registered manager. One relative told us, "The manager and deputy manager have worked very hard to improve everything and the service is going in the right direction. I am really happy with the service and [Name] is settled. I feel I can go to the manager whenever I need to and I can tell staff if I am unhappy and they will take my concerns on board. The staff are very open and honest and I have no regrets about [Name] coming into the service as they receive great care."

All of the members of staff who were interviewed said that they received regular supervision and that they received a paper record of each session. Senior therapists received regular clinical supervision from a consultant therapist who worked outside of the unit. All of the staff interviewed said that they felt supported by the management and that both the registered manager and the deputy manager were approachable. All the members of staff who were interviewed said that it was a good place to work and one member of staff said, "I would be happy for any member of my family to come here." Another member of staff said, "The morale here is much better than when I worked in the NHS" and a third told us, "There is good leadership from the higher management and a high quality of care being provided. I think people are well cared for and I would not change anything."

A wipe clean board in the entrance area had 'We did/said' comments on it as feedback from questions asked by people and relatives. One comment was "There are a lot of agency staff" and the response answer was, "We try to keep agency low and try to use regular agency staff." Another comment was around the delivery of walking and stretching exercises and the response was, "January 2016 we are looking at different approaches being used with dedicated assistants to do these. We will ask for people's feedback in February 2016." There was a suggestion box on the wall and copies of the satisfaction questionnaire next to this for people to take and complete as wished.

The registered manager had come into post in July 2015 and in August 2015 they completed an action plan due to feedback from people, families and staff about concerns within the service. The action points on the plan already addressed by the registered manager included reduction of the use of agency workers, the introduction of a welcome pack for new people, completion of hospital passports and 'This is me' documentation in the care files to make sure person centred information was available about people using the service. The registered manager had started work on improving the records in the care files and was developing the role of the senior rehabilitation assistants. This indicated to us that they were committed to making positive changes to the service.

We saw the November 2015 satisfaction questionnaires completed by people and relatives and these gave a number of very positive responses about the service. People had commented, "Friendly and caring staff who are very professional," "Clean, calm environment for the patients," and "The care my relative has received is outstanding."

The written visions and values for the service were summed up in the Statement of Purpose as, "To deliver rehabilitation which maximises independence and recovery, so people can return home and live more independent lives." Our observations of the service indicated that the registered manager and staff had these as the focus of the care they gave to people and that they were determined to improve the quality of life for those who used the service.

The registered manager and registered provider were fully aware of the need to maintain a 'duty of candour' (responsibility to be honest and to apologise for any mistake made). We saw copies of three letters that had been written to people who used the service about issues they had raised and actions that had been taken to put things right. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The registered manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in January 2016 and covered areas such as reportable incidents, recruitment, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

The majority of staff said they felt supported by their colleagues and there was a clear line of management from the top down to the senior care staff. Staff told us they felt they could be open and honest about care and could speak to their line manager if they had any issues. Staff told us they had the opportunity to attend monthly meetings and said, "These give the team a chance to air any views and we feel 'listened to' with regards to the meetings." We were given copies of the meeting minutes to look at and found the latest one included a 'debrief' on one person who had been discharged from the service. Lessons learnt from this were documented and used to improve practice within the service such as, to have a much more robust admission process including family meetings before admission in order to manage family expectations.