Ramsay Health Care UK Operations Limited

Gardens Neurological Centre

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

The inspection took place on 12 June 2018 and was unannounced.

Gardens Neurological Centre 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. They are registered to provide accommodation and treatment for up to 54 people, aged 18 years or older, with complex long term neurological conditions, brain or spinal injuries.

Gardens Neurological Centre is owned and operated by Ramsay Health Care UK Operations Limited, which is a subsidiary of Ramsay Health Care (UK) Limited. The centre provides nursing care, personal care, medical treatment and diagnostic procedures in a purpose-built environment over two floors. The staff at the centre assists people's recovery wherever possible and specialise in slow stream rehabilitation. Some people had lived there for many years and others were more recent admissions working towards returning to their own homes. There were 51 people accommodated at the home at the time of this inspection.

At our last inspection 24 May 2017 we found that the provider did not take appropriate actions to ensure that people's safety and welfare was promoted and protected and they were in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We also found that the providers quality assurance systems had not identified potential risks to people's safety and wellbeing and they were in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We rated the service Requires Improvement.

At this inspection, we found that sufficient improvements were made to support the rating of Good. Following the inspection on 24 May 2017 the provider submitted an action plan to us to detail how they were going to address the concerns we found. We found that they have completed the actions they told us they were going to do.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff understood their responsibilities in relation to safeguarding. Training and systems in place supported this. While records had some gaps, staff knew how to support people safely in line with their individual assessed risks. Observations demonstrated that there were enough staff available to meet people's needs safely and well. Staff confirmed their competency in medicines was routinely assessed to ensure safe practice. No concerns in relation to prevention and control of infection were identified. Staff confirmed their understanding of their responsibility in reporting and recording accidents and incidents. We saw that lessons were learned after incidents and additional control measures were discussed to minimise the risk of

reoccurrence.

People's needs were assessed and information about their diverse needs was recorded. People were supported by staff who were provided with opportunities for training, skills development and ongoing assessment of their competence. People had choices in relation to food and drink and were encouraged to have good nutrition and fluid intake. People's specific dietary needs in relation to their culture and lifestyle preferences were recognised and provided for. People were involved in decisions regarding the environment of their personal space. The premises offered some challenges in terms of space and decor was tired in places. Staff had received training in and understood the impact of Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for people living in the service. Observation showed that staff sought people's consent for everyday decisions.

People were supported by kind and caring staff. People knew staff by name and were aware who their key worker was. The staff group was from a wide range of different backgrounds and in some cases, were able to speak with people or their relatives where English was not their first language. Staff were knowledgeable about the needs and backgrounds of the people they supported. Visitors were welcomed in the service and people's relationships respected. People's privacy and dignity was appreciated and their independence was promoted in a positive way. People told us and records showed that people had been involved in the planning of their care.

People were supported by a range of professionally qualified staff employed by the provider. There was a permanent GP at the home supporting people`s health needs on a daily basis. A team consisting of physiotherapists, occupational health therapist and nursing staff ensured people`s needs were met effectively. People's care and support needs were planned for and reviewed weekly through multi-disciplinary meetings. The care records could have been clearer in some areas, however, when we shared this with staff, they confirmed they would address this. No evidence was found to indicate that this had had any impact on people's well-being.

The service was developing their approach to end of life care planning by providing training for staff and including relatives as well as people where possible in discussions around their preferences and wishes when people were nearing the end of their life.

People told us staff encouraged them to be involved in their care and retain or regain their independence as much as possible. People were provided with opportunities to engage in social activities of interest to them.

The service has established leadership with a clear chain of command. This helped staff to understand their roles and responsibilities and those of others. The service was effectively organised and well run with an open and transparent culture. The registered manager was supported by a dynamic well -developed management structure and the management team demonstrated a holistic approach and had clear oversight of how the service was meeting people's physical, emotional and social needs.

The service actively encouraged and provided a range of opportunities for people who used the service and their relatives to provide feedback and comment upon the service in order to continue to drive improvement. There was a comprehensive auditing programme carried out by the management team and the provider. Action plans were comprehensive in detailing actions taken, time frames and the responsible person for the actions taken.

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.

Staff had training and were knowledgeable about what constituted abuse and what responsibilities they had to report and document concerns to keep people safe.

Risks to people`s wellbeing and health were recognised, assessed and plans were in place to mitigate these so people were protected from the risk of harm.

There were enough staff deployed to meet people`s needs in a timely way.

People had their medicines administered safely by trained staff who had their competencies regularly checked.

Infection control procedures were adhered to by staff to protect people from the risk of infections.

Is the service effective?

Good

The service was effective.

Staff had access to a comprehensive training programme and had regular supervision and support to carry out their roles effectively.

People were supported to have a nutritious diet and where people had been assessed at risk of malnutrition the dietician and GP were involved in their care.

The premises offered some challenges in terms of space and decor was tired in places, however a rolling maintenance program was in place.

People`s health needs were met by a team of health professionals involved in their care who reviewed people`s health in weekly multi-disciplinary meetings.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring.

People were involved in planning their care and their voice mattered.

People told us staff protected their privacy and dignity.

People were encouraged to maintain relationships important to them. Their visitors were welcome to the home any time they wished to visit.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support from staff who knew them well. However, some areas in care plans needed further developing.

People told us they had opportunities to pursue their hobbies and interests and were happy with the activities provided to them.

Staff attended end of life training to ensure they were skilled and knowledgeable in providing appropriate support to people nearing the end of their life.

People and their relatives knew how to raise complaints and they told us these were appropriately responded.

Is the service well-led?

Good

The service was well-led.

The service had an established leadership with a clear chain of command. This helped staff to understand their roles and responsibilities and those of others.

There were opportunities for people who used the service and their representatives to share their views about the quality of the service provided.

There were quality assurance systems used effectively to ensure the quality of the care provided was maintained and improved where necessary.

People, and staff were positive about the management of the

service.□

Gardens Neurological Centre

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 met 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 under the Care Act 2014.

This inspection took place on 12 June 2018 and was unannounced. The inspection team consisted of one lead inspector, a bank inspector, a primary medical services inspector, a GP, a specialist adviser in brain and spinal injuries and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received the completed document prior to our visit and reviewed the content to help focus our planning and determine what areas we needed to look at during our inspection. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff support people who used the service, we spoke with four people who used the service and five relatives. We spoke with four care assistants, a team leader, a nurse and a physiotherapist. In addition, we spoke with the senior clinical manager and the matron, the registered manager and a volunteer. During the inspection we also spoke with the GP employed by the provider.

We also received feedback from representatives of the local authority commissioning body and health and community services. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to seven people who used the service and other documents central to people's health and well-being. These included staff recruitment and training records, medication records and quality audits.

Good

Is the service safe?

Our findings

People told us their needs were met safely and they felt safe and secure at Gardens Neurological Centre. One person told us, "Yes, (I feel safe). It's the people here. Nice people." Another person said, "Yes, [I feel safe]. The staff know what they're doing." Relatives we spoke with told us they felt people were safe and well looked after. One relative told us, "Yes, [person is safe]. The staff are very helpful and friendly."

Staff were able to demonstrate a clear understanding of what constituted abuse and give examples of how this could happen in day-to-day practice in a care setting. They were aware of what action to take in terms of reporting and documenting their concerns and also how to ensure people`s safety and well-being. Staff knew where to find information on contact numbers for reporting concerns internally and externally to local safeguarding authorities. There was also an on-call system within the organisation to support them out of hours if needed.

Staff were also aware of the whistleblowing policies and procedures and stated that they would contact the local authority to report any concerns if they did not feel that the organisation was listening to them or acting appropriately.

Staff were aware of people's individual risks and how to mitigate these in line with the person's risk assessments and management plans (RAMP). These were developed for each identified health risk as well as risk of the use of equipment needed to meet people`s needs safely. However, some risk assessments could have been better developed to ensure they were fully reflective of what measures were needed to keep people safe. For example, for one person bedrails were in place. No covers were fitted to the bedrail and reference to this was not included within the bedrail risk assessment or the plan of care. Staff spoken with were aware that bedrails were in place and of other risks for the person, such as in relation to choking and the need to be sat up to eat and drink safely. Staff told us that bedrail covers were not required because these prevented the person to access personal things within their reach. Staff agreed that the information regarding the bedrail covers should have been included in the risk assessment. They told us that the risk assessment will be reviewed routinely with the other risk assessments to provide clear evidence of what measures were needed to keep people safe. This was a records matter and there was no evidence of impact on the person.

People who needed constant supervision and one to one support from staff in order to be safe had been supported by staff in a non-intrusive way. We observed one staff member supporting a person on a one to one support. They sat with the person and had conversations and followed the person around without restricting the person`s movements. The staff member explained to the person that they were taking the person`s drink whilst they were walking so they never left the person on their own to help ensure they didn't fall.

People told us there were enough staff to meet their needs promptly. One person said, "They come as quickly as they can. There's plenty of staff. I'm enjoying myself here. I wouldn't change any of the staff." Another person said, "Staff do answer the buzzer, it's not too long." Relatives told us that at times they had

to look for staff as they were not visible in the communal areas. One relative said, "If there are several dependent residents in the conservatory and no staff in sight. We can often go searching for someone. Dependent people should not be left alone."

Staff and observations throughout the inspection indicated that sufficient staff were available to support people's needs safely. Staff told us usually there was enough staff on duty, however on occasion staff reported short notice absences and this meant that staff were short until the shift could be covered. Staff told us that members of the management team were helping on the floor when this happened. The matron told us that people's dependencies were regularly looked at in relation to staffing levels and meeting people's needs and also for staff to ensure workloads were even and manageable. Records also confirmed this.

We found that safe and effective recruitment practices were followed to help ensure that all staff were of good character, physically and mentally fit for the roles they performed. All staff had been through recruitment procedures which involved obtaining satisfactory references and background checks with the Disclosure and Barring Service (DBS) before they were employed by the service.

People told us they received their medicines at the required time and they were happy how staff supported them to take their medicines. Every person had a medicine administration record (MAR) in their name with the associated photograph which ensured staff could identify that person correctly prior to administering their medicines.

There were detailed protocols for medicines prescribed as and when required (PRN), with information regarding signs and symptoms to look for which would indicate that people required these medicines. When we inspected the Jacobs Neurological Centre the sister home of the Gardens Neurological centre owned by the same provider we found that staff had to crush some medicines for people who had a percutaneous endoscopic gastrostomy (PEG) so they could administer these. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when a person cannot swallow their food or drink. We recommended that staff consulted the GP and the pharmacist to ensure that they had clear records and instructions if these medicines could be crushed. At this inspection we found that the matron extended this recommendation to the Gardens Neurological Centre as well and all the medicines administered via PEG in the home were in the process of being reviewed by the GP.

All medicines were kept safely in the locked clinical rooms on each floor and administered by trained staff who had their competencies assessed regularly. Records indicated that medicines were stored at the correct temperature and suitable arrangements were in place for the safe disposal of unwanted medicines. A supply of oxygen cylinders were in some people`s rooms. It was demonstrated that these were regularly checked. Staff`s competencies for oxygen management recently started to ensure that they were knowledgeable and skilled in managing people`s oxygen safely.

Information on procedures to deal with emergencies was displayed including in staff areas. Staff spoken with were aware of fire procedures and action to take for individual people. Personal emergency evacuation plans (PEEPS) were in place for every person to ensure staff had guidance in how to evacuate people safely in case of an emergency. Staff were knowledgeable and had training in fire safety. They told us they regularly had fire drills which ensured they were competent and knew how to evacuate people if there was a need for it.

We observed staff followed infection control procedures, washing hands regularly and using personal

protective equipment when appropriate. The environment was clean and welcoming and we found that thorough cleaning regimes were followed by the housekeeper team to ensure bedrooms and communal areas were regularly cleaned. Risk assessment identified where people were at high risk of infection and had supporting strategies were in place to mitigate this.

Good

Is the service effective?

Our findings

People told us staff were skilled in meeting their needs. Relatives told us they were pleased with the support staff provided to people. One person said, "Staff are well trained. I see the same faces every week." A relative told us, "Staff is very good here. They know what [person] needs. They are getting [person] to walk again. I am very happy with everything."

The staff members we spoke with told us they were provided with training and opportunities to increase their skills and knowledge. They gave us examples of training available to them and these included diabetes, end of life care and tissue viability. Staff confirmed that they received regular supervisions and an annual appraisal. Staff told us they felt well supported by the management team and the systems the provider had in place at the service. One staff member told us, "I've been here a year. I've learnt everything here. I'm well trained, doing my QCF (nationally recognised training) in September. I'm also doing English lessons to improve my grammar. I go to the team leader if I make a mistake or I'm not sure. I'm well trained and supported."

Newly employed staff had an induction training when they commenced employment at the home and they had training in areas like safeguarding, manual handling, infection control and other subjects considered mandatory by the provider. In addition, they shadowed more experienced staff members until they felt confident and familiar with the job requirements.

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 Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff had received training in and understood the impact of MCA and DoLS for people living in the service. People's capacity had been assessed and MCA forms were on file. One staff member told us, "The assumption is that people have capacity until assessed as otherwise. In that case we have to do what is best for them and not for us. Most people can make some decisions and choices and show this in different ways of communication. You have to always ask and be patient."

Observation showed that staff sought people's consent in everyday decisions. For example, we observed staff providing one to one support to a person. Although they had to be in close proximity all the time they always asked the person where they wanted to be and respected their choices. People we spoke with told us that staff asked their consent about the care and support they received. We saw that this was documented in care records. For example, one care plan we looked at evidenced a discussion with a person who wished to be resuscitated if their condition suddenly deteriorated. However best interest decisions needed to be better documented to evidence what options were considered and how the decision was reached in consultation with people`s legal representatives and health professionals when restrictions on people`s freedom were applied in order to keep them safe.

We found that people`s health care needs were effectively supported by staff. We found numerous examples where staff effectively supported people to move back into their own homes or in less supported care services. For example, one person was admitted to the home following a year spent in hospital. When they moved to the home they were not able to walk whilst previously they were independent. The person went through a well set out rehabilitation programme and within six months they were able to mobilise independently and return home.

Another person had suffered a stroke and lost the ability to communicate verbally and mobilise independently. They presented with low mood and left side weakness and no motivation to socialise when they moved in the home. There was a multidisciplinary approach which involved care staff, physiotherapist, occupational therapist, speech and language therapist and the GP working together with the person who gradually improved in mood, speech and mobility over a two year period. We found that recently they were supported to return to their own home. We saw a picture of them smiling and looking happy that they achieved this.

People had their immediate health needs met and monitored by a GP employed by the provider. The GP visited people daily and monitored their health effectively. We found that they maintained close working relationships with specialist medical professionals involved in people`s care. There was a multidisciplinary team approach (MDT) in ensuring people had all aspects of their health and social needs discussed and reviewed weekly. We found that these meetings were well-documented by the GP with clear actions if needed in regards to medicine changes or changes in people`s support needs. However, we found that people and their relatives were not always clear of what expectations to have from the GP. We recommended that the provider gives sufficient information to people and relatives about what the role of the GP was in the home so everyone was clear of what they could expect from the GP and when decisions about people`s health had to be taken by other medical professionals.

People enjoyed the food served. One person told us, "The food is wonderful." People had choices in relation to food and drink and were encouraged to have good nutrition and fluid intake. Relatives told us staff knew people`s likes and dislikes and there were always alternatives offered in case people did not fancy the meals on offer. One relative told us, "[Staff] are aware of what [person] doesn't like. They get an alternative." Staff were aware of people`s goal to reduce their weight and encouraged people to take the low-fat options as recommended by the dietician. Equally risks in relation to nutrition were assessed and people had their food fortified and their weight monitored if they were at risk of malnutrition. We found that staff involved the dietician in people`s care to ensure their nutritional needs were met. People's specific dietary needs in relation to their culture and lifestyle preferences were recognised and provided for if required.

At meal times people were supported by appropriate numbers of staff to ensure they had the support they needed to have a good food and fluid intake.

The environment was calm, clean and welcoming. There were wide corridors which allowed people to access different parts of the home with their wheelchair. However, the environment offered some challenges in terms of space and decor was tired in places. The provider told us they had a rolling refurbishment programme and they permanently improved the environment. The garden was well maintained by a group of volunteers to provide people with the opportunity of spending time outside. We saw that people's rooms, whilst they needed considerable amount of equipment to support them with their mobility and health needs, were personalised and cheerful.

One person told us they were very happy with the environment. They had chosen the colour scheme for their own room. They said, "I chose this, you only have to buy the paint and they will put it up for you. I chose

the curtains too." Sticky labels with the word oxygen written on were noted on all bedroom doors although not every person residing in the home had been using oxygen. The registered manager told us that the reason of having warning signs of oxygen on all bedroom doors was because it was a possibility that at some point in time people moving in those rooms would use oxygen. They told us that for fire regulation purposes they marked the rooms where oxygen was in use on the evacuation plan. Most rooms were single occupancy and therefore people were able to receive their visitors there if they wished to. There were two double rooms routinely used as single rooms and three double rooms normally used as doubles with consent from people or their legal representatives. A large room was also available that could be used by families as required.

Good

Is the service caring?

Our findings

People told us that staff were extremely kind to them and they felt they were like family. One person said, "This is the third place (person`s been), two hospitals and now here. It's as good as I would want; not like an institution, no antiseptic smell. There's a lot of kindness and it's friendly." Another person said, "The staff are kind and caring here. They tell me they love me and they hug me and I hug them, it's lovely. I am happy here."

Relatives told us staff were kind and caring. One relative said, "The staff have endearing qualities. I know the faces; I see the same people. The attitude and approach is brilliant." Another relative said, "Yes, always [kind and caring]. Conversations I've overheard are always kind, gentle."

Observations throughout the day demonstrated that staff were thoughtful, kind and caring towards the people living in the service. Interactions were respectful and friendly. Staff addressed people by their name and ensured that they gained eye contact, or were in a suitable position for the person to see them. One person told us that a staff member had come in on their day off to help them with their make up as they were going to a special event. This really mattered to the person as was the help given to complete accessories for their outfit on the day. The person said, "There are lots of nice people [meant staff] here."

People told us the care and support they received was as they liked. They told us they were happy with the way staff supported they and they felt listened. One person said, "I have a key worker and I discuss my needs." Relatives told us they knew that care plans were in place for people and they were asked to fil in forms and documents in case people receiving support were not able to actively participate in their care planning. However not all the care plans we reviewed evidenced how people or their rightful representatives influenced the care they received.

People told us that their privacy and dignity was respected by staff, including when they had visitors with them. One person said, "Yes, privacy and dignity is always respected." A relative told us, "I have to leave the room [when personal care is being given]. I have faith in what they're doing. The doors and curtains are closed." Some people`s care plans detailed what preference they had in regards to the gender of the staff offering them personal care and this was respected by staff.

Care plans reminded staff to support people's independence. For example, one person needed help with certain parts of personal care but preferred to do other parts themselves. The person told us staff respected this. We saw a drinks bar available for hot and cold drinks were people could help themselves or be supported by staff were possible to get their own drinks.

We saw that private and confidential records related to people's care and support were securely maintained in lockable offices or on password protected computers.

Good

Is the service responsive?

Our findings

People who used the service and their relatives told us they were happy with the care and support provided by staff. One person told us staff listened to them. They said, "They listen. I tell them when I want to go to bed." People and relatives told us their needs and progress were discussed and they knew what to expect from the future. One person told us, "Yes, they talk to me about my health and progress. I wouldn't change anything." One relative told us, "[Person`s] prognosis is poor. This has been explained to me." Another relative said, "[Person] used to have speech and language therapy. There was no progress so it was stopped. I was disappointed but I understood the reasons."

We found that people's care had been planned for and thorough assessments were carried out when people moved to the home. However, some care plans we looked at would have benefitted from more details around people`s needs. For example, one person's care documentation identified that they were of the Jewish faith, however it had not detailed how this impacted on their daily life, nutrition, or care after death. Staff were knowledgeable about this and were able to tell us what this person`s needs were regarding their faith; however, this was not recorded.

People`s care records contained "all about me" with some information about their personal life, relationships and preferences with photographs of family members, important things to know about the person's morning, daytime, evening and night routines.

Care records contained a key information summary sheet which fronted the care plan. This identified people`s immediate needs including needing two or one staff for moving and handling, if they had capacity to make decisions, their ability to communicate needs, their level of independence and where they needed support and also behaviour patterns. We found that care plans were reviewed and where people were able they signed their care reviews to indicate their involvement.

People`s end of life care needs were met by staff. Staff had open and honest conversation`s with people and family members about the expected outcomes for people when they moved to the home. The service was working to improve their documentation in relation to end of life care. A record was maintained of when people and relatives had been offered forms to complete in relation to advanced care planning and preferred priorities of care. This also showed where people had completed forms or had expressed a wish that they did not wish to do so. A meeting had been held as a way of informing people about advanced care planning and a further meeting was planned. One relative told us, "There is a relative meeting this week about advanced care planning."

People were offered opportunities for social interaction. One person said, "We do a fair bit of games. We have days out, go to the cinema and a canal trip. On a Friday we have a picnic outside." Another person said, "They talk to me about my life and choices most of the time. They know me. I do what I like. If my left leg worked – football and pool, darts. But you need to stand up."

There was a varied activities schedule during the week which people told us they enjoyed. The activity

programme Saturday and Sunday simply had "Activity Chest and library available". The registered manager explained that during the week people had an extensive physiotherapy programme and activities and weekends gave people the opportunity to rest and although activities were available these were more relaxed and less challenging. There was a monthly entertainment list to ensure people could plan if they wanted to take part.

On the day of the inspection we observed a volunteer who visited people and brought in pet dogs. They told us they visited weekly and the dogs were always dressed up for special occasions such as the Royal wedding. They told us that people responded well to the dogs and we saw how delighted people were to see the dogs.

A charitable group had been formed to raise funds for equipment and activities to improve the lives of people who used the service and the sister service located adjacent to the Gardens Neurological Centre. The group had helped to recruit and organise volunteers to work with staff to support people to live their lives to the best of their abilities.

People told us they had no complaints about the service; however, they said they knew how to complain if they had any concerns. One person told us, "I would talk to staff or any of the nurses." People's relatives told us that they thought the management team were responsive and they dealt with any concerns promptly. One relative told us, "I did complain and it's been resolved. It was a few weeks ago."

Good

Is the service well-led?

Our findings

Everyone we spoke with told us that the home was well managed. People knew who the managers were and who they could talk to if they wanted. One person said, "Well managed? Yes. [Name of unit manager] is the manager." One staff member told us, "I feel the home is well managed. I know what to do in an emergency." The registered manager was responsible for two Ramsay Healthcare Neurological services on the same site and had an effective management structure in place that ensured they were continuously aware of anything that occurred in either service.

The provider had a well-developed management structure in place. Managers had clear lines of responsibilities for each department the provider had in place to manage all the aspects of the service. The registered manager had an overarching governance system which monitored how each department fulfilled their role. For example, staff who worked in the human resource department ensured that staff only started after they had the required references verified. They also monitored and alerted the registered manager in cases of staff`s professional registration, nurses pin number were due to be renewed. The compliance coordinator collated all the quality audits carried out regularly and ensured all actions were periodically revisited to ensure completion and results from these audits were sent to the provider and discussed in managers meetings.

We found that in addition to the regular well established and rolling audits carried out there were additional audits and investigations prompted by different events reported to the registered manager. For example, two people told us that they could not use the internet. When we reported this to the registered manager they told us they were aware of an issue and it was being addressed.

There were opportunities for people who used the service and their representatives to share their views about the quality of the service provided. People told us there were regular meetings at the home where managers as well as staff attended. One person said, "There are quarterly meetings, there was one last week. All topics are discussed and minuted. It's a dialogue. Managers attend not just care staff. If you raise something it's dealt with within 24 hours." There were also annual surveys sent out by the provider to people, relatives and staff to get their views on the quality of the care provided. An action plan had been developed in response to the areas highlighted by the survey in need of developing further. The survey results were also compared to previous year's results to ensure that the improvements implemented were successful. For example, in 2017 68% of people indicated that they knew who their key worker was in comparison of 14% in 2016. This meant that actions implemented following the survey had led to positive results. The registered manager told us they constantly looked for new and innovative ways which ensured people were satisfied with the quality of the care they received.

Staff told us they felt valued and listened by their managers. We saw that staff had one to one support appropriate for their job roles. For example, a staff member told us they were awaiting their professional registration and whilst they could not take on the fully qualified job role as a physiotherapist they were in an assistant position. This gave them the opportunity to learn people`s needs until they were awaiting their diploma. Nursing staff had support to maintain their professional registration and develop their knowledge

in the areas of their interest. This meant that staff had the appropriate support to acquire and maintain their skills and abilities to provide people with effective care and treatment.

There were various meetings held at each level of the departments. There were head of department meetings, multi-disciplinary meetings and day and nights care staff meetings. We found that staff were given the opportunity to fully participate and be involved in the running of the home. The provider launched yearly HealthCare Awards so individual staff members' efforts could be more formally recognised. We saw that staff were nominated for the different categories by people in the home or their colleagues for Compassion in Care Award, Infection prevention Award and Training and Development Award. The registered manager told us that the staff, residents and relatives were delighted that staff had won both team and individual recognition awards at the Award Ceremony held in May 2018. Categories included Compassion in Care, Customer Service; Leadership and Infection Prevention & Control.

The registered manager and the provider developed excellent links with local NHS trusts and helped people and their families to participate in research done by specialist neurologists from Addenbrooke`s hospital involving brain scans to establish level of brain activity for people who were in a locked in state unable to communicate or respond environmental stimuli.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.