Care Quality Commission

City Health Care Limited

Rossmore

Inspection report

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Date of inspection visit:
31 October 2018
01 November 2018

Date of publication:
16 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed this comprehensive inspection on 31 October and 1 November 2018. The inspection was unannounced on the first day. The service was rated Requires Improvement at the last inspection on 10 October 2017, which was an improvement from the inadequate rating of March 2017. At this current inspection, we wanted to see that improvements had been sustained. Whilst we saw that improvements had been made and sustained in most areas, there remained concerns in Effective and Well-led domains in relation to the stroke service provided to people. The service has been rated overall as Requires Improvement. This is the second consecutive time a Requires Improvement rating has been given and we will meet with the provider to discuss how improvements can be made.

There was a registered manager in post. 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.

Rossmore 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.

Rossmore is situated in a residential area and is several town houses linked to make one building. The service is registered to provide residential care for up to 56 people, although due to refurbishment, the number of beds had been reduced to 50. There are designated beds for stroke rehabilitation, enablement following a period of ill health or hospital admission and for permanent residency. There are bedrooms and communal space on the ground floor and further bedrooms on the upper floors. The service also has a separate building used for therapy support for people recovering from a stroke. At the time of the inspection, there were 17 people using the stroke service, 15 people admitted for support with their enablement and 11 people who lived at the service.

Whilst there were no concerns raised with care and treatment in the enablement service and the main part of the home, there were issues raised by health and social care professionals with management oversight of the stroke service. We found there was an approach to care and treatment in the stroke service that was not as effective as it could be. Staff morale was described as low and there was a lack of teamwork between care staff who worked in Rossmore and external staff who delivered therapy. There were also issues with the consistency of records and some elements of quality monitoring required improvement. Senior management were aware of the concerns and were taking steps to address them. There had been occasions when delays in preparing for weekly multi-disciplinary meetings had impacted on treatment decisions and discharge planning. We found a pressure relieving mattress was not set at the correct level and two other mattresses were displaying a fault. The issues with mattresses had not been identified by staff. Those mattresses registering a fault were addressed straight away by the deputy manager.

We found a breach in regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report. We have also issued a recommendation in Effective for the provider and registered manager to follow through with plans to improve monitoring and preparation for multi-disciplinary meetings.

Staff had completed safeguarding training and knew how to safeguard people from the risk of abuse. They knew the different types of abuse, how to recognise potential signs and symptoms and what to do if they had concerns.

People had assessments completed to identify any potential risks, for example with falls or nutritional needs. These provided guidance for staff in how to minimise risk without detracting from people's choices and right to make their own decisions.

Medicines were ordered, stored and administered safely to ensure people received them in line with prescribing instructions.

People had access to community health and social care professionals when required. There was also a range of external professionals who visited people in both the stroke and enablement service to deliver therapy, medical treatment and nursing care. People could remain at Rossmore for end of life care if this was their choice.

People's nutritional needs were met and their likes and dislikes recorded; menus provided alternatives to the main meals on offer. Drinks and snacks were served in between meals. There were positive comments from people about the meals.

There were meaningful activities for people to participate in and entertainment organised by the two activity coordinators.

People could make their own decisions about their care and staff were aware of the need to gain consent before carrying out care tasks. When people lacked capacity, decisions made in their best interest followed good practice guidelines. The provider worked within current legislation when people's liberty was deprived for safety reasons.

Staff were recruited safely and employment checks were carried out before new members of staff started work in the service. There were sufficient staff employed, which included care and ancillary staff and a range of therapists to provide treatment to people who received a stroke service and enablement before going home. The organisation and deployment of staff within the stroke service had raised some negative comments from staff. Senior management were aware and were taking steps to address them.

There was a staff training and supervision programme to ensure members of staff had the correct skills required to meet people's needs.

There were lots of improvements noted with the environment. It was safe, clean and tidy and a programme of refurbishment was underway. Staff had access to personal protective equipment such as aprons, hand gel and gloves, which helped to prevent the spread of infection. Staff had completed training in infection prevention and control.

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 knew how to protect people from the risk of harm and abuse. There were safeguarding policies and procedures to guide staff and risk assessments to help minimise incidents and accidents occurring.

Medicines were managed safely and people received their medicines as prescribed.

Staff were recruited safely and in sufficient numbers to meet people's needs. There was an issue regarding the organisation of staff and team approach in the stroke service, which management were aware of and trying to resolve.

The service was clean and tidy. Staff had access to personal protective equipment to help minimise the spread of infections.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were concerns that some aspects of health monitoring in the stroke service had the potential to affect discussions, treatment and discharge plans. People who used the service had access to a range of health care professionals.

People's nutritional needs were met and there were positive comments about the meals provided. Menus provided people with alternatives to the main meal.

Staff had access to training, supervision and support to help them feel confident when delivering care to people.

The provider worked within mental capacity legislation when people lacked capacity to make their own decisions.

Is the service caring?

Good

The service was caring.

Staff had a kind and caring approach to people; this was confirmed in discussions with people and their relatives.

Staff promoted people's independence and respected their privacy and dignity.

Staff knew the importance of maintaining confidentiality. People's personal data was stored securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs completed before admission to the service. These assisted staff to complete care plans to deliver care in an individualised way.

People had access to a range of activities to participate in if this was their choice. Activity coordinators helped people who chose to remain in the bedrooms feel less isolated.

The provider had a complaints policy and procedure; people and their relatives told us they felt able to raise complaints knowing these would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The stroke service required more effective management oversight and input as staff morale was low and there lacked a coordinated approach to delivering care and treatment to people.

There was a quality assurance system but this had not been wholly effective in rectifying issues in care records, sustaining improvements in monitoring charts and identifying the need for more vigilance with air flow mattresses.

The registered manager and senior management team were described as supportive, approachable and available when required.

Care Quality Commission

Rossmore

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 31 October and 1 November 2018 and was unannounced. The inspection team consisted of one inspector and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had expertise in caring for an older relative who lived with dementia. The second day of inspection was completed by one inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Before the inspection, we contacted various agencies for information. These included local authority safeguarding, contracts and commissioning teams, and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We spent time in communal areas and observed how staff interacted with people who used the service throughout the day and at lunchtime. We 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 spoke with five people who used the service and four people who were visiting their relatives. We also received comments from a further five people who used the service.

We spoke with the registered manager, the deputy manager, one senior care worker, three care workers and a pharmacy technician. We also spoke with an activity coordinator, a cook, two administrators, a

housekeeper and a laundry assistant. We spoke with a GP, a nurse and a specialist social worker who provided treatment and support to people admitted to the stroke service. We received comments from four night care workers. On the second day of inspection we spoke with eight members of the stroke therapy service and five care staff who provided care to people who accessed the stroke service. We also received comments from four health care professionals who provided an enablement service.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 14 people and monitoring charts for food, fluid intake, weights, wound care and pressure relief. We looked at how the service used the Mental Capacity Act 2005.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

People we spoke with all told us they felt safe in the service and did not report any concerns. Comments included, "The nurses make me feel safe" and "They do fire drills and they say to ring the bell if you need anything." Every person told us they received their medicines on time and pain relief was available when required. People also said that call bell response times were acceptable. Comments were, "It's between 10 and 20 minutes sometimes but no problems", "It's well within 10 minutes at all times", "If you use the buzzer, they soon come and they are all very pleasant" and "They are quick to respond; sometimes there is a bit of a wait but it's not a problem."

The provider had safeguarding policies and procedures to guide staff. Records showed staff had received training in how to safeguard people from the risk of abuse and in discussions, they demonstrated they knew what to do should they have concerns. There were systems in place to manage people's money held for safekeeping within the service, which helped to minimise the risk of financial abuse.

Staff completed assessments to identify areas of risk and potential harm. These included falls, moving and handling, nutrition, fragile skin, and the use of equipment such as bed rails and wheelchairs. The risk assessments were kept under review and updated when required. Each person had a personal emergency evacuation plan (PEEP), which detailed the level of support they would require to exit the building in an emergency.

People's medicines were managed safely and they received them in line with prescribing instructions. Medicines were stored safely and at the correct temperature in a newly refurbished treatment room. Stock was controlled to ensure people did not run out of medicines. People who lived at the service had very detailed information sheets regarding how they preferred to take their medicines and the level of support they required; this information was less detailed for people who used the stroke and enablement service. There were some minor recording issues such as missing protocols for some medicines prescribed with a variable dose or on an 'as and when required' basis. This type of prescribing required a judgement from staff and clear directions to assist them; this was mentioned to the registered manager to address. Staff who administered medicines had received training and competency assessments were carried out.

The provider employed a pharmacy technician who worked there four days a week to monitor medicines management in the stroke and enablement services. They had completed an initial medicines audit when they started in their role in July 2018 and had worked on the provider's standard operating procedures for medicines management. The pharmacy technician highlighted any errors or areas to improve and raised these with staff who administered medicines to people. People in both the stroke and enablement service were encouraged to manage their own medicines in preparation for discharge home. A self-medication risk assessment was completed for each person, which was kept under review. The service worked with other agencies regarding the use of technology and specific equipment to enable people to manage their medicines independently.

The provider used a tool to calculate staffing numbers. This showed there was sufficient staff deployed

within the service; rotas showed there were specific staff designated to the main part of the service and to the stroke service. There had been concerns raised by staff within the stroke service that staffing levels had fluctuated due to short-notice absences. We saw that when available, members of staff from the main part of the service were deployed to make up the shortfalls; however, the care support was specific in the stroke service and not all the staff had received the correct training. The registered manager told us an agency staff who was trained in stroke rehabilitation was used for the service and they always tried to ensure staff who had received appropriate training were deployed there. The staff rotas had not been adjusted to evidence when care staff had been transferred to the stroke service, which made it difficult to audit. This was discussed with the registered manager to address.

Staff within the stroke service told us when they had the correct amount of staff available, there were no concerns about providing safe and appropriate care to people. The stroke service had a maximum of 17 people admitted at any one time and all were at various stages of their recovery. When fully staffed, there was a senior care worker with five care staff in the morning and four in the afternoon. A stroke specialist nurse visited daily to complete nursing tasks and there was a range of therapy staff such as physiotherapists, occupational therapists and technicians. We discussed staffing levels with senior management; they were aware that the issues to address related to the organisation of shifts, and care staff and therapy staff working together as a team. This was to be addressed with specific managers of staff.

There were no concerns raised about staffing levels in enablement and the main part of the service. Health professionals in the enablement service told us there were sufficient staff deployed to meet people's needs and any short notice absences were filled with agency staff. Comments included, "Staffing is good; I am always able to find a carer when needed and buzzers get answered quickly."

There were separate ancillary staff such as catering, domestic, laundry, administration and maintenance, which enabled care staff to focus directly on care tasks. The activity coordinator had dual roles and assisted people at mealtimes as well as organising activities.

There were good systems in place to ensure staff were recruited safely. Full employment checks were carried out before new staff started working at the service. New staff had an induction, which helped them orientate to the service and expected ways of working. They completed shifts shadowing more experienced staff and were enrolled on the Care Certificate if they were new to the caring profession.

The service was clean and tidy, and equipment used was checked and well-maintained. Staff had access to personal protective equipment such as gloves, aprons and hand gel, which helped to reduce the spread of infection.

Requires Improvement

Is the service effective?

Our findings

People who used the service had access to a range of community healthcare professionals involved in their care and treatment. For those people who used the stroke service and enablement service, healthcare professionals such as GPs, physiotherapists, occupational therapists, speech and language therapists and specialist nurses visited them daily and devised treatment plans for them. People who lived at Rossmore had visits from their own GP and the local district nursing team. Staff within the service monitored people's healthcare needs and contacted health professionals such as dieticians in a timely way when required.

People told us staff knew how to care for them and contacted health professionals when required. They also said they could make their own decisions such as where to sit during the day, what activities to participate it, what to eat for their meals and the times of rising and retiring. Comments included, "It's okay for rehabilitation", "I would recommend it; they give me exercises to do", "They get the doctor if needed" and "All my decisions are my own."

Relatives said, "The staff called an ambulance recently and they [relative] were checked out but there wasn't a problem; I can't fault them" and "I have known a GP come out at 2am and district nurses visit throughout the night; they have just sorted out a chiropodist for them."

Despite positive comments from people who used the service, there were concerns raised during the inspection from health professionals and relatives about the effectiveness of some aspects of the stroke service. This included, on one occasion, a delay in obtaining a urine sample requested by medical staff, shortfalls in completing monitoring charts and recording practices that made it difficult to audit if action had been taken. On some occasions, these had led to delays in treatment, information not readily available for relatives and had the potential to impact on discharge planning. For example, a delay in obtaining a urine sample had led to a delay in a specific medicine being prescribed. One person had lost weight and there were concerns they had not been receiving food supplements. Another person had gained weight again, when there were concerns about their pre-diabetic status. On looking at concerns raised in previous multidisciplinary meetings since July 2018, there were recurring themes. These were shortfalls in follow-through from week to week when requests were made for action, recording errors or omissions, and observations not completed.

During the inspection, a relative of someone in the stroke service told us they had difficulty getting basic information from staff regarding their family member. Another relative commented that staff had overlooked the fact their family member had not had their bowels open for several days. They also said communication between staff could be improved to ensure changes identified by health professionals were implemented in a timelier way.

We have issued a recommendation for the provider and registered manager to follow through with plans for a monitoring tool to ensure better preparation for multi-disciplinary meetings.

During a tour of the environment with the deputy manager, we noted two airflow mattresses were beeping,

which indicated a potential fault. These had not been noticed by staff. There was also one airflow mattress that was not set at the correct level for the weight of the person who occupied the bed. These issues were discussed with the registered manager and senior management during feedback so that action could be taken to address them. More vigilance was required as incorrect/faulty mattress settings had the potential to cause to pressure damage.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 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 authorisation procedure for this in care homes is called Deprivation of Liberty Safeguards (DoLS).

People who met the criteria for DoLS had their capacity assessed and four applications had been made to the local authority supervising body. These had been authorised and three of them were in the process of re-application. Capacity assessments and best interest decision-making documents were held in people's care files. This meant important decisions were discussed and only made when they were in people's best interest and the least restrictive option. Staff had a good understanding of consent and described how they obtained this before carrying out care tasks. Staff completed training on MCA and DoLS.

People told us they liked the meals provided. The menus gave people alternatives to the main meal on offer and there were snacks and drinks served in-between meals. People's nutritional needs were assessed and individual care plans provided staff with information about likes and dislikes. These were more comprehensive for people who lived in Rossmore but we saw the speech and language therapist had been involved in risk assessments and treatment plans for people who used the stroke service. Since the last inspection, a small number of people in the stroke service had received food and fluids at an incorrect texture; this was now monitored more closely and a checking system put in place to ensure people received the correct meal. Staff showed us a pocket-guide each one of them had received as a prompt for textured meals and fluids; they said this was a useful tool and kept them up to date with recent changes in textured meals and fluids.

Comments about the food and drinks included, "It's good and there is plenty. They bring the menu and I choose; I enjoyed the stew and dumplings and I can ask for a can of coke anytime", "The fish and chips on Fridays are very good", "They do a nice chicken pie and the Sunday roast is lovely", "The food up to now has been very nice and there's plenty to eat" and "The food is good and drinks are available when you want them."

Staff received training, supervision and support. Records showed staff had access to a range of training; the records detailed the required frequency of each training course, when this was completed and when an update was due. Comments from staff included, "All the care staff and seniors in the stroke service have received training" and "The training has helped enormously." Staff confirmed they received formal supervision meetings with their line manager where they could discuss issues affecting their role and training and development needs. Health professionals in the stroke service provided training for care staff in rehabilitation methods.

Good

Is the service caring?

Our findings

There were very positive comments from people who used the service about the staff team. They said staff supported them well and spoke to them in a kind and caring way. Comments included, "They are very good and try and help in any way; nothing is too much trouble", "They are excellent; I can't fault them and they always have a smile on their faces" and "The staff are kind; they are all okay." Relatives and friends said, "There are some amazing, compassionate staff and they treat him as an individual", "They are friendly and hardworking, and don't treat people like they are idiots" and "I have no concerns; I am very happy with them."

All the people spoken with, and their relatives and visitors, said they would recommend the service to other people. One of the notice boards had a selection of 'thank you' cards on display. We checked a number of these and saw they contained lots of compliments about the staff team approach.

Comments from health professionals in both the stroke service and enablement service were positive about staff approach. Comments included, "They have been promoting mobility and activities of daily living independence at all times" and "Staff promote privacy and dignity at all times."

People said that staff respected their privacy and dignity and gave examples of them knocking on bedroom doors before entering and closing curtains around beds in shared rooms during personal care tasks. Both these examples were observed by inspectors during the inspection. We also saw privacy signs on bedroom doors for staff to use when they were completing personal care tasks; these reminded other staff to knock and wait before entering. We observed some people had voile curtains at the doorway to their bedroom; this was to ensure a measure of privacy when the person preferred their bedroom door open but they rested in bed.

Comments from people included, "They always cover me with a towel and make me feel comfortable" and "They knock on the door if it's closed to see if you are alright." Staff were clear about how they promoted people's privacy, dignity and independence. They said, "You respect the person's wishes to make their own choices, listen to the person and ask their opinion and don't speak down to them" and "We draw curtains and shut doors when giving care."

Staff had received training in equality and diversity and described how they ensured people's views and protected characteristics were respected.

People were provided with information to enable them to make informed decisions. There were various notice boards around the service, which had information for people. These included activity plans, newsletters, minutes of meetings, the complaints procedure, the last inspection rating and the service's statement of purpose. There were also quality assurance results in the form of 'You said, We did' information and photographs and names of staff on duty. There was a menu board on display in the dining room and a copy of the week's menu was placed in people's bedrooms.

Information was provided in a format which met accessible standards. For example, one notice board in the lounge reminded people in pictorial format of the day, date, year, season and current weather. We noted this was an accurate reflection of the day. There was signage to remind people of where bathrooms, toilets and communal areas were located. The activity coordinator had collated information about local facilities in a hotel-style file; this was kept in the lounge. It contained information about local churches, cafes, takeaways, shops including those selling ethnic products, hairdressers and chiropodists. The newsletter was bright and cheerful with pictures of the activities on offer.

We observed staff were attentive to people throughout the day. They checked people had sufficient to eat and drink, fetched additional items from the kitchen for them and sat and chatted to them.

Staff understood the need to maintain confidentiality and referred to only discussing people's care needs in private. There were staff offices available so phone calls and meetings with health professionals or visitors could be completed in private. Computers were password protected and care records were stored securely. Staff personnel records were also held securely.

Good

Is the service responsive?

Our findings

People who used the service told us staff had been responsive to their needs and talked to them about their care plan. Comments included, "It's just like a home from home", "They responded quickly when I was unwell", "The staff are brilliant and respond very quickly" and "All emergencies are quickly responded to by all staff." Other comments were, "I'm going through my care plan on Monday" and "The care plan is discussed with you and updated as your rehab progresses."

People who accessed all three parts of the service, the main area for permanent residency, the stroke unit and enablement placements, all had assessments of their needs completed prior to admission. These varied in complexity but all provided a decision as to whether the person's needs could be met within the service. When people were placed by the local authority, we saw 'My Life, My Way' assessment records were in place. Risk assessments were completed to determine any areas of need that required closer monitoring.

People had care plans developed from their assessments. The care plans for people who lived in Rossmore were very detailed and included lots of personalised information. One person had anxious behaviour which could be challenging for staff; it was clear a lot of work and time had been taken to obtain the level of information included in their care plan. The person's care plan described in detail how staff were to support them with all aspects of their assessed needs. For example, there was guidance for staff in what could trigger their anxiety, how this was expressed, the impact their environment had on them and approaches to use when completing different tasks. There was information about what the person liked to do, what was important to them and how best to support them. There was information regarding the type of dementia the person had and the possible impact this could have on their cognitive abilities and on their emotions. The information helped staff to see them as a 'person' and not just as a recipient of care.

The care plans for people within the stroke service and enablement were functional and task orientated. These provided basic details and guidance for staff in how to support people and could be more person-centred. We discussed this with a specialist stroke nurse, the registered manager and deputy manager to look at introducing a 'my routine' or 'what's important to me' page to the care plan, which could include more personalised information. In discussions with care staff who worked in the stroke service, it was clear they knew people's needs and could contribute to the information written in care plans.

We saw evidence that people's specific needs had been attended to, for example with bed extensions for tall people and voile curtains at doorways for those who liked their door open but spent time in bed during the day. There was a selection of moving and handling equipment specific to people's needs and the use of technology to assist people with self-medication and communication.

People could remain in Rossmore for end of life care if this was their choice. There were policies and procedures for end of life care. Staff had referral information, criteria and a flow chart to guide them when making referrals to the specialist palliative care team. This team was comprised of a palliative medicine consultant, GPs with special interest in palliative care, Macmillan clinical nurse specialists, pharmacists, physiotherapists and occupational therapists. The team worked with the district nurse and care staff to

develop an end of life care plan appropriate for the person. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents and preferred place of care information were in place for some people. The registered manager had sourced staff training in end of life care and this was to be incorporated into the training plan.

The service employed an activity coordinator from 7.30am to 4pm, five days a week and another member of staff for two days a week to complete more one to one with people. The timing enabled them to support people to eat their breakfast and with care tasks if required. The activity coordinator told us they visited each new person to find out their likes, dislikes and previous interests; they also spoke with relatives to gain information. There was a monthly newsletter and an activity programme, which was colourful and in pictorial format. Activities included quizzes, pet therapy, chair exercises, baking and gardening clubs, hand care, games, bingo, crafts, seasonal celebrations and visiting entertainers. There were outings organised to a local social club, shops and parks in warmer weather.

People told us there was sufficient activities provided. Comments included, "There is a music club and a breakfast club where I make my own breakfast", "I watch television; there is enough to do", "I enjoy the bingo", "They ask me but I would rather watch TV" and "There is a list of activities to do." On day one of the inspection, we observed people enjoyed the gardening club in the morning and a Halloween party with an entertainer in the afternoon. The lounge was decorated with banners and items for Halloween.

The provider had a complaints policy and procedure, which referred to timescales for acknowledgement, investigation and ensuring the outcome was sent to people. There were also procedures and information for escalating complaints to senior management and other agencies if required. The procedure was on display in the service and people spoken with told us they felt able to raise concerns knowing they would be addressed. Comments included, "I did make a complaint and it was addressed" and "My daughter complained and it was sorted out quickly." Relatives described instances when they had complained about issues and said these were addressed quickly and they were happy with the outcome.

Requires Improvement

Is the service well-led?

Our findings

People told us they would seek out the registered manager if they had concerns, although some people were unsure who they were. Some people were admitted for short stays in the enablement service so it is acknowledged they may not have full knowledge of the registered manager.

We had concerns regarding oversight of the stroke service. Both care staff and therapy staff within the stroke service described morale as low. There was a lack of teamwork between care and therapy staff, which led to an approach to delivering care and treatment to people, and documentation, that was not as effective as it could be. There were concerns about preparation for the weekly multi-disciplinary team (MDT) meetings, which had led to observations, test results and information not being readily available to inform discussion, treatment and discharge planning. The registered manager and senior management had been informed of ongoing issues and fortnightly meetings with MDT staff had taken place to discuss the concerns. We were told the meetings helped to improve the situation initially but improvements had not been sustained. During the inspection, we received information about concerns relating to the MDT which had taken place during the inspection. These issues have been described in the Effective domain.

We discussed these concerns with the registered manager and senior management during feedback and have been assured they are fully aware of the issues and have plans in place to address management oversight. We saw the responsibilities of nursing and care staff in the stroke unit had been redefined because of ongoing concerns, in the hope that these would provide clarity. Following the inspection, we received information that a team building exercise had been sourced in August 2018, because of the acknowledgement by senior management that improvements were required; this had not been actioned yet but we were informed that it would be a priority. We will monitor these issues and request updates to be reassured progress is made.

The morale and teamwork between care and therapy staff in the enablement service were described as very good. There were no concerns expressed about staff morale in the main part of the service where people lived permanently.

Records relating to people who lived permanently within the service, for example, care plans and monitoring charts were completed thoroughly. However, records such as care plans and monitoring charts relating to people in the stroke and enablement services were not always sufficiently comprehensive, accurate or up-to-date.

For example, care plans for people who used both the stroke and enablement service were generic task sheets with limited personalised information. One person's daily records referred to 'pillows in place at all times' but there were no directions of how and where the pillows should be positioned for them on any care plan. Another person's care plan stated they had a catheter and described the re-catheterisation process, but not how care staff were to support the person to manage their catheter. The same person received their nutrition through a tube directly into their stomach and staff were fully aware of this, however, their generic care plan referred to staff encouraging them to eat small and frequent meals. There were discrepancies in

weight recordings, which had not been rechecked for accuracy. Reposition charts did not specify the frequency of pressure relief, although some care plans did. There were gaps in observation charts. Bowel monitoring charts were not always completed fully. Therapy staff, and the specialist stroke nurses who visited people in the service, recorded information on an electronic system that care staff were unable to access. Subsequently, it was difficult for care staff to ensure they were following the correct instructions.

There was a quality monitoring system in place; audits had been completed and some areas continued to be improved, for example medicines management, infection control, hygiene within the service and the physical environment. However, audits had not captured concerns relating to records and there were ongoing issues with staff not completing observations or acting in a timely way. There was no system to check mattresses were set at the correct level for the people who used them. We were told that at times there could be shortfalls in the information and handovers when people were transferred from hospital to the enablement service. This had the potential to impact on issues such as supplies of continence care products and medicines. There was no audit system for this issue to establish if lessons needed to be learned and communication improved.

Not having a governance system that includes effective oversight, accurate records, assurance and auditing is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local Clinical Commissioning Group had responded to concerns raised in February 2018 and visited the stroke service. Recommendations were made and an action plan completed, which included training for staff in observations and completing a specific monitoring tool. The last fortnightly meeting with senior managers and MDT staff dated 24 October 2018 referred to further training being arranged for the monitoring tool used for people in the stroke service. As a response to feedback during the inspection, the deputy manager told us they would attend the MDT meetings in future to support the senior care staff. They also developed a checking tool to ensure people's observation records were accurate and up-to-date for discussion in the meetings.

Staff told us the registered manager and senior management team were approachable and made themselves available in the service, should staff wish to raise concerns. People also said senior management had been proactive in listening and seeking feedback regarding their concerns. We saw senior managers completed visits, spoke with people who used the service and staff, and checked the environment. Methods of communication included staff meetings, shift handovers and 'huddles', which were short catch up meetings to exchange important information. Staff said, "Management support you if you need to talk about problems", "[Names of registered manager and deputy manager] are approachable and will listen" and "It's a lot better than it used to be; [name of registered manager] wants to sort out things and asks your opinion of how it can be sorted."

People who used the service were asked for their views in meetings and in the completion of surveys. The records of meetings and results of surveys showed people were listened to and action taken to address shortfalls. The results of meetings and surveys were on display in the service. Despite the team issues in the stroke service, the last survey completed between April and September 2018 had eight responses with positive comments about their experience. In the same timeframe, there were also positive comments from ten respondents in the main part of the service.

The provider had a refurbishment plan and lots of improvements had been made to the interior and exterior of the building. The decoration looked fresh and clean, bathrooms and bedrooms were being refurbished and other rooms such as the treatment room had been upgraded. The refurbishment was an ongoing

process.

The registered manager completed notifications of accidents and incidents that occurred in the service. This enabled the Care Quality Commission and other agencies to monitor how these were managed. Accidents and incidents were analysed so lessons could be learnt to prevent reoccurrence.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured there was effective management oversight of the stroke service and a consistent system to monitor the quality of records.