Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 and 27 June 2017 and was unannounced. The Dean Neurological Centre provides accommodation for 60 people who require personal care with nursing. There were 54 people living in the centre at the time of our inspection. The centre provides personal care and support to people with complex long term neurological conditions, brain or spinal injuries and people who require on-going support and assistance to maximise their functional ability.

The centre is purpose built and set over two floors, each floor comprising 30 individual bedrooms, communal lounges and dining rooms. On the ground floor there is therapy department and people have access to several decked areas in the garden.

There was registered manager in place as required by their conditions of registration. 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 and their relatives were mainly positive about the caring nature of staff; however people's care plans and daily care records did not support the safe delivery of care. Not all people had recorded guidance or care planning which reflected their support requirements and risk management. Staff did not always follow safe infection control practices. People were not continually informed of the care being provided.

People benefited from a new medicines management system to ensure they received their medicines as prescribed.

Staff enjoyed working at the centre. There were suitable numbers of staff to support people; however the registered manager was reviewing the deployment of staff across the centre to ensure people received care and support in a timely manner. Effective recruitment systems were in place to ensure people were cared for by staff with good character. Staff understood their responsibility to report any accidents, incidents or safeguarding concerns.

Systems to monitor staff training and support had generally improved. Staff told us they felt trained; however their work based skills were not regularly assessed to ensure they were competent to support people with complex skills. A series of competency assessments were being developed to evaluate the skills and knowledge of staff. Not all staff training was mandatory which meant some staff were at risk of having gaps in the knowledge to care for people. A clear frame work to monitor the specialist clinical skills that nurses required to carry out their role was not in place other than the nurse's professional registration requirement. Not all staff had supervision records which highlight their professional development or act on any concerns.

Staff and people's their relatives felt communication across the centre needed to improve. A quality improvement lead was helping to recognise shortfalls in the service and drive improvement in the centre. The provider had different means to regularly audit and check on the quality of the service being delivered, although the system had not always been effective in driving improvement across the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk at not receiving the care they required to support their health and well-being needs as records were not consistently in place to manage and monitor their risks. Staff did not always follow the provider's arrangements to prevent the spread of infections through cross-contamination.

There were sufficient numbers of staff to meet people's needs, although the deployment of staff needed to be reviewed in some areas. However, not all staff had been assessed as being competent to carry out their role safely.

Suitable systems to check the employment history of new staff were in place.

People were protected from harm as staff were knowledgeable about reporting any safeguarding concerns. New systems were in place to ensure that people's medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt they were well trained to carry out their role. Plans were in place to monitor and implement effective competency assessment of staff skills to ensure they had the appropriate knowledge to support people.

Where people lacked the mental capacity to make decisions about their care, decisions made in their best interests had not always been recorded in accordance with principles of the Mental Capacity Act.

People had access to drinks and enjoyed their meals.

People were supported to access health care services as required.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and positive manner. They ensured people's dignity was respected at all times.

People and their relatives were positive about the approach and attitude of staff who cared for them. People were encouraged to express their views and supported to make choices about their day.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care records did not always provide staff with the information they needed to support people.

People did not always receive care that was personalised to their needs or informed of their care and support.

The manager dealt with any issues from people and their families on a day to day basis and had acted on people's concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems and action plans put in place by the provider had not been effective in making the required improvements to people's care records.

Improvements were needed to ensure staff's supervision was effectively monitored so that the registered manager could identify and take action to address shortfalls. .

Staff and some relatives felt communication about people and the management and governance of the centre needed to improve.

The Dean 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 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 26 and 27 June 2017 and was unannounced. The inspection team consisted of a lead inspector, a specialist advisor 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. The expert had experience and knowledge of caring for people with physical disabilities.

Before the inspection the provider completed a Provider Information Return (PIR).we reviewed the information we held about the service as well as their previous inspection history and statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the centre and observing how staff interacted with people. We spoke with seven people and seven people's relatives and visitors. We looked at eight people's care plans and associated records and pathway tracked the care and support of six people.

We also spoke with 13 care staff and two nurses as well as kitchen and maintenance staff, the training coordinator, the activities coordinator, the quality improvement lead and the registered manager. We also liaised with four health care professionals.

We looked at recruitment procedures and the training and development of all staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the centre.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2016, we found people's risks were not always recorded as people's care plans did not provide staff with all the information they needed to know about people's risks. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action. They sent us an action plan which stated how they would meet the regulations in full by 30 June 2017. At this inspection we found the information in people's care records were still not sufficient to ensure staff would have all the information they needed to know how to keep people safe. Further improvements were needed to ensure the provider met the requirements of this regulation.

Care staff and nurses were knowledgeable and responsive to people's care needs and risks. Staff monitored those people with complex needs from a distance outside their bedrooms. They were confident in supporting people who were ventilated or needed respiratory care and the actions they should take in an emergency. This was confirmed by therapy staff and people's relatives.

However people's care plans and daily care records did not support the safe delivery of care. For example, some people received nutrition and fluids via a percutaneous endoscopic gastrostomy (PEG) tube (a method of receiving fluids and nutrition directly into the stomach when it cannot be provided orally). The type of tube being used for one person was not reflected accurately in their care plan, and for another person, there was no record that the required flushing of their PEG tube had taken place to ensure it remained safe to use in line with the guidance that had been provided by health care professionals. People's records relating to their PEG needs were not accurate and placed them at risk of receiving unsafe care.

Some health care professionals reported they felt the centre was making some progress in managing people's complex needs as tools had been implemented to monitor and identify risks to people's health and welfare. However, people were at risk of not receiving care and support in line with their needs as their records and monitoring charts had not always been completed by staff. For example, the documentation of the monitoring of some people's weight had not been carried out in accordance with the centre's protocols or health care professional guidelines. Another person's daily nutritional records had not been completed as recommended by a health care professional. People's fluid intake was not recorded for all people who required their fluid intake to be monitored every time they received a drink. Nurses and health care professionals could therefore not judge from people's records whether they were at risk of losing weight or had received sufficient nutrition and hydration. One person was potentially at risk of becoming unwell as guidance on the monitoring of their blood sugars was not in place for staff to follow. Staff did not always have sufficient information to know how to support people to stay safe.

When people's risks changed, staff had sought additional advice from specialist health care professionals. Staff were able to describe the actions they had taken to implement health care professional recommendations for two people, but this was not always recorded. For example, the monitoring charts for some people who required to be repositioned in bed to prevent pressure areas developing were not always completed every time they were supported to change their position to relief pressure on their skin. There

was no detailed record for one person's wound care that showed how nurses had monitored and evaluated the healing progress of their pressure ulcer. This meant there was limited recorded evidence that people at risk of skin damage had received the required support to prevent the development of pressure ulcers. Nurses could therefore not judge from people's records whether care staff had implemented people's skin care plans and when pressure ulcers did occur whether these had been treated in accordance with a prescribed wound plan.

General risks assessments in relation to the health and safety of people, staff and the environment had been carried out to ensure people lived in a safe and clean environment. However, records to guide staff in the management of one person who had been admitted to the centre with a history of an infectious condition and were still presenting with associated symptoms were not in place.. There was no record whether the person's health had been reassessed. Without a risk assessment record staff might not always know what precautions they should to take to reduce the risk to others and the person of cross contamination.

An accurate, complete and contemporaneous record of the care and treatment that was provided or needed to be provided to each person was not available for staff to know how to keep people safe. . This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had also received specialist training and mentoring from health care professionals in for example, safe PEG management and ventilation of people. Improvements were being made to ensure staff would be competent to undertake safe care, for example three care staff members had been trained to deliver training and assess the competency of their colleagues in ventilation and tracheostomy care. Some time was needed for the provider to complete the competency assessments of staff to ensure they had the skills and knowledge to deliver people's care safely.

The centre was clean and systems were in place to manage people's personal and clinical waste; however we found some areas in the management and prevention of the spread of infection required improvement. For example, a clinical waste bin was overloaded with sealed bags of clinical waste in one bathroom, although the registered manager explained that they had communicated and reiterated good practices of managing people's waste with staff. We observed staff appropriately wearing disposable gloves and carrying out good hand hygiene practices, however not all staff wore aprons when supporting people with their personal needs.

Since our last inspection a new medicines management system had been implemented in conjunction with a new community pharmacist. Regular meetings occurred between the registered manager and the new pharmacist to ensure that there was a clear understanding of the protocol and procedures between the centre and the pharmacist and to identify any shortfalls. Nurses had a sound knowledge of the new system and were fully aware of the processes for the ordering and storage of medications, including the safe storage and administration of controlled drugs. They had undergone training in the safe handling of medications and what to do in the event of a medicines incident. Protocols were in place for people who were prescribed medicines to be administered 'as required'.

People were supported by suitable numbers of staff. The registered manager had recruited a number of additional staff since our last inspection which had decreased the dependency on people being supported by agency staff. The registered manager explained that some new staff had been recruited via recruitment agency which allowed them to observe their practices and approach before offering them a permanent position. Additional nurses and care staff were made available when required for people who received additional funding for individual one to one support. Whist there was enough staff on duty; some staff expressed concerns about the allocation of work across the units and felt overworked which was impacting

on staff morale. We raised this with the registered manager who assured us that actions were being taken such as reviewing the deployment and staffing levels in the centre.

Staff records showed there were suitable recruitment systems in place to protect people from those who may not be suitable to care for them. Appropriate health and background checks had been carried out on all new staff before they started to work with people, although gaps in people's employment history and reason for leaving their role had been discussed during interview but not always recorded. These questions were added to interview questions to ensure the recording of the discussions were captured as part of the interview process.

People told us they felt safe living at The Dean Neurological Centre and were protected from harm or abuse. For example, one person said, "Yes I feel very safe here, I get my medicine on time and everyone knows how to support me." Staff had the knowledge and confidence to identify safeguarding concerns and acted on any concerns to keep people safe. For example, one staff member said, "I am aware of how to whistle-blow and would have no hesitation in doing so if I thought the residents were being harmed here in anyway. We have training in safeguarding and I know the 'no secrets' guidance." The registered manager had worked with external agencies and stakeholder where concerns about people's safety had occurred.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2016, we found that people were at risk of receiving ineffective care as all care and nursing staff had not always received training and support to undertake their role effectively. Records of people's mental capacity to make specific decisions about their care and treatment were not always evident. These concerns were a breach of regulation 18 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action. They sent us an action plan which stated how they would meet the regulations in full by 30 June 2017. At this inspection we found improvements had been made in the training of staff. However more time was needed to ensure all staff would complete all their required training and be assessed as competent to undertake their care and nursing tasks effectively. Decisions taken in relation to all the people's care and support had still not been recorded. Further improvements were needed before the provider met the requirements of the regulations in relation to people's care records.

We checked whether the service was working within the principles of the MCA and whether any condition on authorisations to deprive a person of their liberty were being met. 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 who were able to express their views and opinions were consulted before staff provided them with support and care. For example, one person said, "I am always involved in my care, I tell the care staff how I like to be cared for.'' Staff had a basic understanding of the MCA and told us the actions they would take to ensure people who were unable to express their views and choices were being treated in their best interest such as gathering information about people from their relatives or from the person's care records to ensure they understood people's preferences. We observed most staff interacting and gaining consent from people before they provided care or support to people.

Assessments of people's mental capacity were in place for most people where staff had been concerned about their ability to make significant decisions about their care. However this was not consistent for all people. For example, mental capacity assessments of people's ability to consent to the use of bed rails were not always in place. There was no clear evidence in people's care records of when best interest decisions had been made on behalf of them or whether people had a lasting power of attorney to represent them in the decision making process. This meant the service had not continually recorded people's consent lawfully using the principles of the MCA.

Records of the care and treatment provided to the people and the decisions taken in relation to their care and treatment was not consistently recorded. This is a continued breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

At the time of inspection, approximately three quarters of staff had completed all their training which was deemed as mandatory by the provider to meet people's needs. For example, staff were required to attend a half day refresher course on topics such as fire safety, infection control, health and safety and basic life support. Plans were in place for those staff who had not completed or updated all the required mandatory training to receive this training. The provider had started assessing the specialist clinical skills required by care staff and nurses but some skills still required to be assessed, monitored and refreshed to ensure people received effective care. For example, in the use of syringe drivers which helps to manage people's medicines and reduce symptoms by delivering a steady flow of injected medicines continuously under their skin.

Specialist health care professionals that worked closely with the service told us t staff had sought their professional advice and had found they were increasingly responsive in implementing their recommendations. However they felt further improvement was required in the assessment and monitoring of staff knowledge in the management and support of people with complex needs. We addressed this with the training coordinator who told us a series of work based competency tools had been developed and were about to be implemented to assess the skills and understanding of staff in key areas such as bowel and bladder management and postural management along with a system to monitor the frequency of competencies assessments to ensure the skills of staff were embedded into their care practices. Sometime was still needed for the provider to complete all the planned staff training and competency assessments to ensure staff could meet people's needs effectively.

Most staff told us they felt trained to carry out their role; however some staff felt there were gaps in some of their skills such as oral care or epilepsy. This was discussed with the training coordinator who told us they frequently sourced and planned additional specialist training for nurses and care staff however these courses were optional to attend and often poorly attended. For example, records showed end of life training was made available but attendance had been poor as it was an optional course. The therapy team had produced some training sessions on subjects such as good practices in relation to respiration management and basic neurological awareness but these had been poorly attended and temporarily suspended. We were informed that the courses would reconvene in the near future.

We received mixed comments from staff about the support they received. Some staff told us they felt supported and met with their designated line manager for supervision (one to one support meetings) approximately every three months as well as receiving an annual appraisal; although others reported they did not always receive regular one to one meetings. We requested an up to date matrix and found that approximately 20% of staff had not received a formal supervision session in 2017. This meant that people were not always cared for by staff who benefitted from professional support in their role. The registered manager recognised that the shortfall in staff support sessions and stated that they would reinforce the importance of carrying out frequent support sessions with the key staff members who were responsible for this role in line with the provider's policy. However, new staff met with their supervisor regularly during their probation period and staff frequently received an unplanned support meeting which was recorded on 'a job chat form' to ensure all staff development and support was documented.

Therapy staff were also required to complete the provider's mandatory courses but were responsible for their own professional development and clinical supervisions. Care staff were also supported to undertake additional qualifications to support their role and the centre was working with local universities to provide placements for students such as nurses.

New staff were required to attend an induction day to understand the provider's, expected standards of care, internal processes and policies including an awareness of the fire safety procedure. New care staff also commenced an induction training programme in line with the care certificate. Their skills and knowledge

was assessed before they were deemed competent to work as part of the care team. Staff with health and social care experience were required to complete a self-assessment tool of their knowledge and skills and additional training was provided to address any gaps in their knowledge.

We found that improvements had been made in the training and support of staff and plans were in place to further progress the professional development of staff. Plans were in place to assess the competencies and skills of staff to ensure people were cared for by staff who fully understood their needs.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff supported people in the least restrictive manner and when required the registered manager had applied to the local authority to gain authorisation to deprive people of their liberty, where alternative methods of support were not viable.

People were required to order their meals from a set menu in advance. Alternative meal options were made available if requested but we were told there were mainly only cold meal options available. People were offered a choice of drinks with their meal and hot and cold drinks were available throughout the day. People were provided with adapted cutlery and crockery to support their independence in eating and specialist diets were catered for in accordance to their needs. Staff supported people who required assistance with their eating with dignity and people were offered food at their own pace.

Since our last inspection, staff had formed better links with health care professionals and had actively sought specialist advice and support where needed. Specialist professionals helped to monitor people's well-being and progress and provide staff with some work based training. A GP regularly visited the centre and provided on-going medical advice and support. A new system of capturing any medical input was documented to give people a chronological order.

Good

Is the service caring?

Our findings

The centre was spacious and accessible to those people who required medical equipment or used wheelchairs to mobilise around the centre. People were encouraged to personalise their bedrooms with photographs and objects of interests where possible.

We saw a number of warm interactions between people and staff. Staff ensured people's dignity and pride was considered at all times. For example, we saw staff straightening people's clothing and assisting them to wipe their face and hands and ensured people looked presentable. We observed staff supporting and reassuring people in a caring and appropriate manner when they became distressed. Staff chatted with people and complimented people about their clothing and hair. They demonstrated good listening skills and allowed people time to speak at their own pace.

People had been supported to ensure their human rights were respected. Where required staff had supported people to use an advocate to assist with decisions around accommodation; retaining links with family and consider different treatment. Staff supported people to make decisions about their day such as taking part in activities or where they wished to sit throughout the day.

People spoke positively about the care staff. We received comments such as "The staff are lovely and the care is excellent" and "I came here 2.5 years ago for respite, though I liked it so much I decided to move in''. One person said "Staff are very caring and they listen to me", although another person when asked if they liked living at the centre said, "No I don't, there isn't anything good about living here." One staff member told us they were working with this person to help them settled in since their recent admission into the centre.

People were supported to be as independent as possible. Staff gathered around one person and wished them well as they were leaving the centre after several years of support and therapy. They were moving into their own private accommodation which had been adapted to meet their needs. The registered manager explained how they had worked with the person to improve their quality of life and levels of independence to maximise their potential before they returned.

Some relatives commented on the high quality support and care provided to their loved one and said, "They are spot on here, there's always someone about to see to him if he makes a mess'' and ''Staff are very good here, they banter and improve the mood of the centre". Others complimented the caring nature of the staff. Where known, people's cultural and religious needs were supported. We were told that staff had spoken to people's relatives and had researched into people's religion to gain a better understanding of their beliefs such as the refusal of certain medical treatments, care needs or diet preferences.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2016, we found the details and support requirements of people's needs in their care records were inconsistent. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action. They sent us an action plan which stated how they would meet the regulations in full by 30 June 2017. At this inspection we found sufficient improvement had not been made and people's records still did not reflect their support requirements and the care they had received. Further improvements were needed to ensure the provider met the requirements of this regulation.

People who relied on staff to support them with the daily personal care and monitoring of their general health were at risk of not receiving the support they required to maintain their health and well-being. For example, the monitoring charts of some people who required regular support with their oral care and bowel management were not consistently completed. This meant staff could not judge from people's records whether care had been received or refused so that action could be taken to review their care arrangements. The assessments and care plans of one person who was receiving end of life care had not been updated to reflect their current support and treatment needs. Although staff could describe this person's support needs; without an accurate and up to date care plan staff who did not know this person well might not have all the information they needed to know how to meet their changing needs.

People's care records were not always reviewed or dated and their daily notes completed by care staff were not always legible. Records therefore could not reliably inform nurses and health professionals whether the care people received had been effective in meeting their individual needs. A senior staff member felt that some staff did not understand the importance of documenting in detail significant incidents to assist them in monitoring people's well-being.

Plans were in place to review and improve the format of people's care records with an emphasis of on highlighting people's risks, goals and desired outcomes. However we were concerned about the delay in getting these improvements implemented. Staff continued not to have all the information they needed to meet each person's needs and people remained at risk of not always receiving care that met their needs and preferences.

There continued to be a shortfall in the maintenance of accurate, complete and contemporaneous records in respect of each person. This is a continued breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We found some people's care plans did provide clear guidance about how people's specific care should be managed such as the support they required with their mobility, hair care or catheter management. Therapy staff explained that they were working with the care team to embed therapy goals into people's care plans and to encourage staff to consider and document more multi-disciplinary goals so that staff understood the importance of good postural management in relation to people's well-being. Two relatives raised concerns about the therapy hours their relatives received. This was discussed with the lead therapist who told us

people's therapy was dependent on the hours which were funded by the paying authorities.

Staff did not always engage people with communication needs when undertaking daily care tasks. For example, we saw a number of warm interactions between people and staff; however some staff did not always demonstrate a person centred and inclusive approach when they were supporting people who were unable to verbally communicate with their care needs. We observed staff monitoring and checking people's individual medical equipment or administering their medicines with limited or no engagement with the individual. This meant staff had not taken the opportunity to socially interact with people and people were not fully being informed of the care they were receiving.

People who had difficult with their memory where not always reminded of the choices they had made to ensure it met their preferences. It was evident during our lunch time observations that some people could not always remember the meals they had ordered. For example, people comments included "I can't remember what I've ordered, it just turns up", "I have no idea what I ordered it was such a long time ago although it's generally nice whatever I'm given" and "I can usually remember, though sometimes I get it wrong." A system was not in place to help people to remember the meals they had ordered.

We observed the levels of interaction between staff and people during meal times varied.
People who could not initiate social contact might not always receive the support they needed to remain engaged. Staff interacted spontaneously with those people who could communicate but there were limited interactions with those who were unable to verbally communicate during the lunchtime period and people might feel isolated and dis-engaged. This was raised with the registered manager who felt that a greater emphasis should be made on staff observations when supporting people with their care in conjunction with their supervision meetings. They agreed to address this issue with staff during the unit meetings.

People were supported to maintain relationships with their family and friends or to develop a romantic relationship in the centre. However people's sexual needs were not always explored and routinely assessed unless they raised it with staff. Plans could therefore not always be made to support people to meet their intimate relationship needs,

People did not consistently receive care and support which was personalised around their needs or informed of their care and treatment. This is a breach of Regulation 9, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People with emotional needs were at risk of not being suitably supported by staff who were able to respond to their mental health needs. Staff told us they had built up strong relationships with some people and had a greater understanding of their emotional needs and how to support them with their anxieties and frustrations. However, two staff members shared with us that all staff would benefit from additional psychological training to support people as not all staff had the skills to support people who had greater emotional needs. However people were supported to access psychological professional support if individual funding was made available.

The centre had employed a new activities coordinator who was making progress with gathering information about people backgrounds and interests and would be planning more individual activities with people. The registered manager told us they were encouraging every member of staff to provide meaningful and social interactions and activities with people. People enjoyed activities such as word games, hand massages and sensory activities. Some people were supported to play games on an electronic device.

Complaints were managed in line with the provider's policy. Where complaints had been made the

management of the centre, a representative of the provider had investigated and responded to the complainant concerns. The registered manager told us they aimed to hold a 'residents/relatives forum' every three months. They informed us these forums were not always well attended and were considering alternatives methods to capture people's feedback and views about the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2016, we found the provider's audits and governance tools were not always effective in driving improvement. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action. They sent us an action plan which stated how they would meet the regulations in full by 30 June 2017. At this inspection we found sufficient improvement had not been made and further improvement was needed in relation to the auditing and governance of the service for the provider to meet this regulation. .

The management of the centre was working on an action plan with significant stakeholders and commissioners to ensure people received care and treatment which was safe and responsive to their needs. The provider had an auditing system in place which was part of their clinical governance process. For example, systems were in place to monitor people's medicines and the environment such as health and safety and infection control. Any shortfalls and trends were reviewed and added to the centre's action plan and were discussed and reviewed in the clinical governance meeting as part of the provider's quality improvement process.

However we found the systems being used to monitor the quality and risks of the service were not always effective in driving the service forward as the required actions to improve the delivery of service had not always been made. For example, a review of the standard of people's records had been carried out in March 2107 which had identified a shortfall in people's care records. Our findings found that any action taken as a result of the audit had not been effective as people's care records did not always reflect their needs.

Following our last inspection, the provider had employed a quality improvement lead to review the format of people's care records with an emphasis of highlighting people's risks, goals and desired outcomes. Once approved, a pilot of the new care plan would be implemented and reviewed before the new system was implemented. However this action had not been sufficient to ensure people's records improved and reflected their current needs and risks by 30 June 2017 by when the provider told us they would meet the requirements of the regulations. At this inspection we found people's care plans and daily care records in relation to their weight, skin, PEG and ventilation management still did not support the safe delivery of care. The provider's systems had identified risks in relation to people's care records. Plans had been put in place to address this shortfall but sufficient action had not been taken to improve the quality of care plans and daily records to mitigate the risk of people receiving unsafe care. We raised concerns about the timeframe of the implementation of the new care record systems with registered manager. They recognised that the development of new care planning was a work in progress and that immediate action was required to address the current shortfalls in people's care records.

Action had not been taken to improve the service's communication with staff to ensure people's dignity was maintained. At our previous inspection we recommended that the service sought reputable guidance around the management of communication with staff that allowed people's privacy and dignity to be maintained, however the service had not acted on our recommendation. At this inspection we still found signs were displayed in people's bedrooms to give staff guidance on how to assist people with their needs;

that may have compromised people's dignity and privacy. This was raised with the registered manager, who stated they would consult with people and their relatives to find an alternative method to inform staff without compromising people's dignity.

The registered manager had made improvements to the systems and processes for monitoring staff training and support. However the system to monitor the assessment of staff competencies in line with their training and skills they required to carry out their role was not effective. For example, staff had recently been trained by a health care professional in the management of people's PEGs; however their knowledge had not been assessed to ensure their skills were embedded into the practices. For example, the mismanagement of one person's PEG by a staff member who had recently been trained in PEG management had not been identified by staff. This had been identified by a visiting health professional who took action to ensure the person was safe. Staff had failed to identify this as a safety incident and had not reported this appropriately in accordance with the provider's accident and incident policy. The registered manager failed to recognise this as a potential incident of neglect that needed to be reported to CQC so that we could monitor whether appropriate action had been taken to keep people safe. The provider's quality assurance audits did not identify this shortfall. The frequency of staff supervision sessions managed by the line managers of staff was not always kept up to date to ensure a reliable monitoring system of their support requirements. Therefore the registered manager did not have the information they needed to monitor whether all staff had received their required supervision. When we received the updated matrix we found 20% had not received the required supervision. Improvements were needed in the monitoring of staff supervision to ensure the register manager could promptly identify shortfalls and take action to ensure staff would receive their supervision.

Where accidents and incidents had been identified, staff had recorded and reported the details of the incidents on the provider's central system. The incidents were reviewed at clinical governance meetings as well as analysed for any patterns and trends. The registered manager gave us examples of the action they had taken when patterns had emerged from their analysis. However, the accident and incident procedures were not always effective in identifying safety incidents or bad practice so that action could be taken to keep people safe and prevent recurrence.

Protocols were in place for people who required medicines as needed such as for pain relief. However, there was little evidence that the effectiveness of the use of the medicines was being evaluated to ensure people were receiving medicines which were suitable for their needs.

Systems were in place for staff to provide their views of the service but their feedback had not always been used to improve the service, For example, the results of a recent staff survey carried out by the provider indicated that staff had mixed feeling about the culture and values of working for the provider. It was not clear how the provider was addressing the results of the survey and managing the staff spirits. The registered manager told us the results of the survey would be discussed with staff during the next staff meetings.

Staff supervision records prompted the supervisors to ask staff about subject's such as their wellbeing, areas of responsibility and working with residents and relatives. However, the supervisors recording of staff discussions and professional development were limited and there was no record that concerns or discussion points had been acted on. For example, two staff supervision records had indicated that staff had raised concerns about the cleanliness of the centre. The level of detail of staff supervision records was raised with the registered manager who stated they would address this with the line managers who were responsible for supporting staff.

Staff we spoke with raised concerns about the poor communication from the management and senior staff

around changes in people's care requirements and were unsure if actions had been taken when they had reported any concerns to the service. Staff told us they would benefit from more frequent staff meetings to improve communication about people's needs. For example, one staff member told us they didn't feel valued or respected and said "We work as a group of staff out there. There are others that don't help or work as a team, especially seniors" and another staff member said, "We do our best but we get talked down to and not listened to."
A handover meeting to share information about people occurred between the nurses during the shift changeover. Care staff had the option to attend the meeting or listen to a taped version of the handover which could be also listened to during their shift as required.

Records shared with us showed that staff and department meetings had occurred across the centre but these were not regular and did not capture the views of all staff. Relatives also felt the communication from the management team needed to improve around the sharing information about their family member's well-being and running of the centre. This was discussed with the registered manager who told us they would review the frequency and timings of the staff meetings across the centre to assist with the sharing of information and feedback from staff and consider alternative ways of improving the communication with relatives.

Health care professionals also reported to us that communication from the centre was variable. The centre was working with other agencies to pilot a new way of sharing information about people's needs and share key information with other health care agencies especially if they are admitted into hospital or transferred between services.

Systems to assess monitor and improve the quality and safety of the service were still not always effective in driving improvements in the service. This is a continued breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Plans were in place to monitor the call bell systems to ensure staff responded to people's requests for assistance in a timely manner. The registered manager told us they were working toward the centre's clinical strategy which included providing care which was 'focused in the best outcome for our resident' and collaborative working with other health care agencies. The registered manager and staff were also working alongside other health care professionals to manage and monitor 'key performance indicators' in relation to people's wellbeing.

Some health care professionals reported they felt the centre was making progress in managing people's complex needs as systems had been implemented to monitor the management of their risks, although further improvement was required in the management and monitoring of people's needs and associated medical equipment. Health care professionals told us there were on-going plans to monitor the management and monitoring of people's needs. The registered manager was also reviewing the provision of supplies required for people's personal care such as pads and wipes to ensure people had sufficient supplies following a recent system changes.

Other representatives of the provider also monitored the quality of the service being provided, the premises and equipment. The maintenance team overviewed the utilities and maintenance of the centre and worked with the fire brigade and ensured suitable systems were in place to check the fire and emergency systems of the centre. Plans were also in place to train and upskills the nursing staff to be fire marshals. We discussed with the maintenance team the frequency of fire drills in the centre and the benefits of extending the fire training to family members as some family members spend long periods of time in the centre.
The registered manager had been in post for several years. They shared with us the complexities of

managing a service that supports people with complex neurological needs and diverse health issues. They explained that they were caring for people with an increased high dependency of needs; however they received regular support from specialists who helped to monitor those people who required ventilation and tracheostomy. They told us their on-going challenges was to manage the expectations of people, families and stakeholders so people had a clear understanding of people's goals and possible ceiling of people's progress and the care and treatment available. Staff told us they enjoyed their work but some were concerned about the lack of support. However other made comments such as "I like the Manager, she is friendly and listens to me" and "I know where to go if I want to change something."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care specifically for them and had not always been supported to understand their care and treatment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's care plans, risk assessments, monitoring records and people's consent to their care and treatment were not effectively and consistently recorded. Audits and governance tools were not always effective in driving improvements. Systems to act on staff feedback were not always effective.

The enforcement action we took:

We issued the provider and registered manager with a warning notice in relation to regulation 17(1)(2)(a)(b)(c)