Care Quality Commission

Queen Elizabeth's Foundation

Queen Elizabeth's Foundation Brain Injury Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection which took place on 16 and 19 November 2015.

Queen Elizabeth's Foundation Brain Injury Centre is a residential facility providing rehabilitation services for people with acquired brain injury and neurological conditions. The service is registered to accommodate up to 28 people. Accommodation is organised across a range

Summary of findings

of buildings that include independent living facilities to supported living for the more dependent person. At the time of this inspection there were 16 people living at the service.

At the time of our inspection the service did not have a registered manager. 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 and associated Regulations about how the service is run. The provider had recruited a new manager and the service was being overseen by a registered manager from another service operated by the provider until the new manager commenced employment which was planned for January 2016.

In the previous six months prior to our inspection there had been a number of changes at the service that had not been managed well. As a result, staff morale was low and communication was poor. A number of staff had left the service and management of staffing impacted on the service that people received. At times, people did not receive safe and consistent care and support.

People told us that they felt safe however, we found that robust safeguarding procedures had not been followed when information of concern included allegations of abuse had arisen. This placed people at risk of harm. The management of risks to people's health and wellbeing was not robust and affected their safety. Systems did not ensure that equipment and the environment were assessed and action taken to ensure it was safe.

People's care needs were not always assessed and care documentation was not always complete or reflected individuals current needs. This put them at risk of inconsistent care and/or not receiving the care and support they needed.

Staff had not received regular, formal support to understand their roles and responsibilities. A training programme was in place however staff said that staff shortages impacted on them being able to attend training. Staff were unsure who they were accountable to and what they were accountable for. There was a lack of communication and involvement from management regarding the day-to-day things that affect their lives and work.

Robust audit and monitoring systems had not been operated to assess, monitor and improve the quality and safety of services to people. As a result, risks to people's health, safety and welfare had not always been mitigated.

People said that they were happy with the support they received to maintain good health and with their medicines. Records and discussions with staff evidenced that the service liaised with a range of professionals to ensure people's health and rehabilitation needs were met.

People said that they were happy with the quality of food provided at the service and that they received support to increase their skills in line with their rehabilitation programmes. As part of the rehabilitation programme provided at the service each person had a timetable, unique to their needs that included therapeutic services. The service had a dedicated therapy rooms which included a physical therapy gym, music room and a fully equipped working radio station.

People were consistently positive about the caring attitude of the staff. They said that staff treated them with dignity and respect and treated them as individuals. Positive relationships had been formed between staff and people. Staff were seen to treat people with genuine compassion.

Queen Elizabeth's Foundation Brain Injury Centre was last inspected in December 2013. Two breaches of the regulations were identified. These related to consent and the environment and were breaches of regulations 15 and 18 of the Health and Social Care Act 2008 Regulations (Regulated Activities) 2010 which under the current amended Regulations equate to Regulations 11 and 12 of the Health and Social Care Act (Regulated Activities) 2014. At this inspection we found that sufficient steps had been taken and the breaches had been met. However, we have made a recommendation in the body of our report in relation to consent.

As a result of the feedback that we gave at the end of our inspection the chief executive of the service informed us that no new people would be admitted until the issues had been resolved and the service stabilised.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Summary of findings

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

We found a number of breaches 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us that they felt safe in the home. Recruitment processes that the provider operated ensured staff who worked at the service did not pose a risk to people. However, staffing levels did not ensure that people received safe and consistent care and support.

Safeguarding referrals had not been made and sent to the local authority safeguarding team when complaints included potential allegations of abuse.

Risks to people were not always assessed or managed safely, putting people at risk.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

People were not supported by staff who received formal supervision and appraisal. A training programme helped staff to gain the skills and knowledge needed to care for people. However, staff vacancies impacted on the ability for staff to undertake training.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) as applications to deprive people of their liberty had been made.

People were supported to maintain a healthy diet and told us that food at the home was good.

People had access to various healthcare professionals so that their health care needs were met.

Is the service caring?

Good

The service was caring.

People were involved in making decisions about their care and treatment.

People told us that they were treated with kindness and that positive, caring relationships had been developed. People were treated with dignity and respect. Privacy was promoted.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive the care and support they required at the time they needed it.

Summary of findings

People's needs were assessed and when recommendations were made by external professionals these were acted upon.

People were supported to participate in rehabilitation programmes that improved their independence.

People felt able to express concerns and these were acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Changes at the service had not been managed well and this had resulted in a demoralised workforce, poor communication and significant shortfalls in service delivery.

People received an inconsistent service. Quality assurance processes did not always identify aspects of the service that required improvement and when they did action was not always taken to rectify issues in a timely way.

Incidents that had occurred at the service had not been reported to the CQC appropriately.

Queen Elizabeth's Foundation Brain Injury 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 16 and 19 November 2015 and was unannounced. The inspection team consisted of four inspectors who had knowledge and experience of people with physical and nursing needs.

We did not ask the provider to complete a Provider Information Return (PIR) as the inspection was brought forward due to information of concern that we received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed information that we held about the service and the service provider. This included statutory notifications sent to us by the provider, previous inspection reports and information of concern. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with four people who lived at the service and two relatives. We also spoke with two nurses, the head of nursing, the head occupational therapist, head psychologist, the facilities manager, a maintenance person, the medical director, seven rehabilitation assistants, the chef, the acting manager and the chief executive.

We observed care and support being provided in communal areas of the service and also spent time observing part of the evening mealtime experience. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the service was managed. These included six people's care records, staff training, support and employment records, quality assurance audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Queen Elizabeth's Foundation Brain Injury Centre was last inspected in December 2013. Two breeches of the regulations were identified. These related to consent and the environment and were breaches of regulations 15 and 18 of the Health and Social Care Act 2008 Regulations (Regulated Activities) 2010 which under the current amended Regulations equate to Regulations 11 and 12 of the Health and Social Care Act (Regulated Activities) 2014.

Inadequate

Is the service safe?

Our findings

The majority of staff told us that staffing levels impacted on the care people received. One member of staff said, "There aren't enough staff, no. For example, people aren't able to go out at weekends a lot of the time because either there's no driver or not enough staff to accompany them. It comes down to boots on the ground and there just aren't enough". Another member of staff said, "A lot of staff are leaving and that's making it worse". A member of the nursing staff said, "One weekend we were two staff down and couldn't get cover. I came in and did one of the shifts".

The manager told us that the service was divided into two "wings" both of which was allocated four rehabilitation assistants who provided the day to day care and support to people and two nurses during the day. In addition, a head of nursing, medical director and therapy teams that included speech and language, psychology, occupational therapy and physical therapy were allocated during the day Monday to Friday. At night, we were informed that staff consisted of three rehabilitation assistants and one nurse. A member of staff who had responsibility for staff told us that staffing levels were decided on the assessed needs of individuals and their funding status. They also said, "The majority of people need help hoisting, and with continence, mobility and eating".

On the first day of our inspection we asked to view rotas and for information about permanent staff that had completed shifts, agency cover, vacancies and details of any shifts that had not had the required numbers of staff on shift. This information was not available. On the second day of inspection the manager told us that the member of staff who had access to these was off work and the records could not be accessed. Therefore, records were not available to confirm if staffing was being maintained to the levels described by the manager.

However, on the first day of our inspection the manager confirmed that there was no SALT due to sickness and that there were a number of staff vacancies but that they did not know the specific details and numbers. Supervision records for two members of staff dated October 2015 had raised concerns that on two occasion's nurses had not been on shift during the night. A member of staff told us that on other occasions this year nurse shifts were not covered. Complaint records also included concerns raised by staff regarding staffing levels at the service and how this had impacted on the service people received.

On the second day of our inspection staff informed us that the service was short staffed and this was confirmed by the manager. Staff told us that this had impacted on the care that people received. For example, one member of staff said, "Today we only have three rehab assistants on each team instead of four. So night staff had already showered and put X (resident) back to bed because they knew we would be short staffed in the day". We discussed this further with staff who confirmed that they person concerned was funded one to one staff support. They told us that due to the staff shortage they were unable to provide this until they had assisted all others with their morning care. In order to mitigate the risks, the person was put on 15 minute observations until one to one care could be provided.

Another member of staff also confirmed that the service was short staffed on this day and that this was not an unusual situation. They said, "Today is just an example. There are only three staff and a nurse on each corridor. Due to the needs of people we just not having quality time with people. One corridor has three high needs people, a one to one person plus four other people. Six of these people need help to get up and require two staff to do this. I would say 60% of shifts in the last six months have been short staffed".

A third member of staff said, "Yesterday and today I have felt quite upset. Communication is very poor. Yesterday two people didn't work and this was not passed on so when we tried to call the agency for cover it was too late. Then on the afternoon two of us had to go out which left even less staff available for people. Today the agency sent a nurse who didn't know the clients. Luckily X (nurse) came in and showed them how to do the meds. I feel quite angry".

The above evidence demonstrated that there were not always sufficient numbers of staff to safely support people with their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, in the main, people who lived at the service told us that they felt safe and that there were sufficient staff to meet their needs. One person said, "Staff

Is the service safe?

are always around to help us. I have never had a problem". Another said, "I feel safe, staff are nice to me". A third said, "The staffing at the weekend could improve as sometimes we don't have any drivers. I like to go to church; I go about once a month. I can't go more often as there is no driver." A relative said, "There is always plenty of staff around, we have never know it to be short staffed".

We were told the provider operated an internal 'bank' of existing staff and the use of agencies to cover vacant shifts. A locum psychologist had been recruited to cover the head psychologist who was due to leave. Recruitment checks were completed to ensure staff were safe to support people. Staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID.

Robust procedures had not been followed to ensure people were safe from harm or abuse. When looking at complaint records for 2015 we identified seven situations that should have been reported to the local authority safeguarding team and to CQC but had not been. These included an allegation of verbal abuse and allegations of neglect and acts of omission. The manager confirmed that these had not been reported to external agencies. This meant that potential safeguarding situations were not known to all agencies that had a responsibility to monitor people's safety and wellbeing. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our concerns we asked the manager to notify the local authority safeguarding team of the unreported incidents within 24 hours our inspection. We received written confirmation that this was actioned and were subsequently told that there had been 12 incidents that should have been reported rather than seven.

Surrey County Council safeguarding information about the process that should be followed if abuse is suspected was displayed in communal areas of the service. However this was out of date and did not reflect the new Care Act. The manager's office had the up to date policy and procedure in place but this might not have been accessible to all staff when required.

Despite this staff that we spoke were able to explain the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let Social Services know if no-one here would do anything". Another staff member said, "I have done safeguarding training quite recently and I do feel I know what to look out for". Information about abuse was displayed around the service, such as 'break the silence posters' in the activities area where everyone could see it. Safeguarding leads had been identified and their names and photos were displayed where people could see them, such as at the entrance to the Carpenters unit. People said that they would speak to the manager or chief executive if they had any concerns.

Risks to people were not always managed safely. Incident records detailed one person who required a headrest with integral head band which supported their head whilst seated in their wheelchair. While being escorted out in the community the head band had failed and staff had to hold the person head in position in order that their airway was not restricted. A risk assessment was in place but this did not include equipment failure, nor was it unique to the person concerned and their physical conditions. Another incident record detailed the behaviour of another person where they had pinched a member of staff and attempted to bite another. There was no behavioural risk assessment in place or behavioural management guidelines to assess and manage these behaviours. A third incident report detailed that as a result of a lamp in a person's room falling a light bulb smashed and electrical wiring was left exposed that posed a risk of electrocution. An email was sent to staff requesting that the lamp be removed if this were to happen again. The service uses agency staff who do not have access to this information and therefore would not know what to do if this incident occurred again.

There was an electronic incident and accident reporting procedure in place. The procedure included a line manager or head of department at the service to investigate any causes and to complete an action plan, a senior manager to ensure actions were completed and a health and safety officer to sign off once complete. The health and safety officer was also responsible for collating reports and analysing for trends. The system had not identified the issues we found during our inspection despite having the different stages for a range of people to monitor that appropriate and safe action was taken. The manager confirmed that the electronic system was used to identify and manage risks but had failed to ensure timely action was always taken.

Inadequate

Is the service safe?

We also found that other risks associated with the above three people were not managed safely. One was in a minimally conscious state and was fed via a percutaneous endoscopic gastrostomy (PEG) feeding tube. PEGs can be used when a person cannot swallow or the risk of choking is very high. It involves placement of a tube through the abdominal wall and into the stomach through which nutritional and medicinal liquids can be infused. As this person was clearly at high risk of problems associated with immobility, we examined documentation related to nutrition and the risks of developing pressure sores. We noted this person had not received a nutritional risk assessment since April 2015. In addition, they had not undergone a Waterlow Pressure Area risk assessment since June 2015. The assessment form stated reviews should have been completed monthly or sooner if there was a change in the person's needs. We examined the body map in the care plan and noted it showed a 'small round red mark 1cm across' on their abdomen. However, there was no subsequent mention of this in the care plan so it was not possible to ascertain whether this had improved or worsened.

A second person, who had recently been admitted to the service, had a pre-admission report that made no mention of the person's high risk of choking or dysphagia (difficulty in swallowing). The person was admitted with a syringe driver in use which contained medicine to manage their medical condition. A syringe driver is a small, portable battery-driver infusion pump, used to give medication subcutaneously via a syringe usually over 24 hours. None of the staff were aware of the presence of the syringe driver before admission and none had received training to manage it. In addition, the care plan for this person did not contain any dated entries until 14 November 2015, nine days after admission. The person's dysphagia was only mentioned once in the care plans and this entry was not dated or signed. We spoke to the manager about this situation who showed us documentary evidence that this was being investigated by the chief executive.

A third person's diet and weight including dietary preferences assessment concluded they were at risk of choking. However, their nutritional risk assessment, undertaken at the same time, concluded they 'had no difficulty' with eating. Another care plan, for fourth person who was fed via a PEG, did not contain any nutritional risk assessments since August 2015. Therefore, it was not possible to ascertain whether there had been any weight loss or the emergence of new potential risk factors.

Timely action was not always being taken to ensure the environment and equipment was safe. Profiling beds had not been serviced for three years and there was no documentary evidence that checks had been completed in line with the Provision and use of Work Equipment Regulations 1998. Other aspects of the service and equipment had been checked to ensure it was safe for people. These included hoists and slings, small electrical items, gas boilers and laundry equipment.

A property condition survey was commissioned by the provider two years ago which reported on the whole building. A number of immediate actions were recommended, some of which had been acted upon and others that had not. For example, we saw that tiles had fallen from the bathroom wall in the main building and others were coming away from the wall. There was no action plan in place as a result of the survey or an environmental risk assessment that detailed how the identified risks would be managed to keep people safe. The manager advised us that they had a quote for works pending to modernise and fix the existing bathrooms and toilets. Quotes had been received, however the provider had put this out to tender again due to the initial excessive cost. The manager could not give a date as to when the proposed works could begin. Other areas of concern that we identified included dirty and rusted shower chairs, damaged flooring in a shower room, and rusted grab rails.

The above evidence demonstrated that care and treatment was not being provided in a safe way to people as risks were not being assessed and action was not being taken to mitigate risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the potential risks to people we instructed the provider to assess the toilets and bathrooms and to supply documentary evidence to us within 24 hours of our inspection of actions taken to mitigate the risks and this was provided.

Despite the above, a relative told us that they were happy with how risks were managed for their family member. They said, "Staff have gone through the risks with us, e.g.

Is the service safe?

they don't put up X (family member) cot sides as she may climb over. Instead they lower her bed, and they have the alarm mattress so they know if she has come off of the bed".

As a result of our previous inspection a compliance action was set (now known as a requirement action) in relation to some aspects of fire safety and the environment. At this inspection we found that sufficient steps had been taken and the requirement action had been met. All doors now had fire seals in the doors, except the kitchen door. Fire door closures were in place and windows had been made safe by using a protective film. Personal emergency evacuation plans (PEEPS) were in place for people which would help them move safely from the home if needed, in the event of a fire. However, the designated fire marshall at the service was not aware of these and what they were. After of our inspection we made a referral to Surrey County Council Fire Safety Officer as the service had not had a fire safety audit in the last five years to ensure that the fire safety works had been carried out to a satisfactory standard.

People said that they were happy with the support they received to manage their medicines. One person said, "Staff told me what they are for, and I researched them myself. I have the facilities to get online here. If I wasn't sure of my medicines I would ask staff". Another person said, "I get them on time and I know what they are for".

The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. We noted staff locked the medicine trolley when leaving it unattended and did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted all MAR charts contained a list of people's diagnoses, allergies and possible side effects of the medicines they were taking. Staff were knowledgeable about the medicines they were giving.

We observed the administration of medicines via the PEG during our visit and noted it was conducted in a safe and effective manner, in line with people's tube feeding prescriptions and protocols. People who used PEGs had their medicines stored in locked cabinets in their rooms, to which only trained staff had access.

All medicines were delivered and disposed of by an external provider. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in locked trollies in a lockable room. Medicines requiring refrigeration were stored in a lockable fridge, which was not used for any other purpose. The temperature of the fridge and the room which housed it was monitored to ensure the safety of medicines.

Requires improvement

Is the service effective?

Our findings

Staff did not receive sufficient support to fulfil their roles and responsibilities. We asked about how staff were formally supervised and appraised by the provider. None of the staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member said, "That seems to have gone by the board". Another staff member told us, "I can't think when I last had. It was so long ago. It was not last year and might be longer than that. I have no designated supervisor at the moment as far as I know". A third staff member said, "There's definitely a disconnection here between managers and staff. Not having supervision doesn't help". A fourth staff member told us, "Nothing is running systematically. Things are being missed, including supervision". Discussions with people responsible for completing staff supervision and examination of records confirmed that staff had not received regular, formal supervision and appraisal.

We asked how registered nurses kept their professional expertise and knowledge up to date and relevant. We were told the head of nursing provided clinical supervision and guidance to registered nurses. The head of nursing received clinical supervision from an external source. However the registered nurses told us they had not had any formal supervision.

We spoke with staff about the training opportunities on offer. One staff member said, "There are definitely areas for improvement. There's less training than there used to be but there are more people with nursing needs. There should be more training but we don't get it". Another staff member told us, "The work is changing and the training doesn't match that". We asked staff if recent training had been offered that would reflect the care and nursing needs of the people they were looking after. One staff member said, "I've done catheter care training". We asked this staff member if they had undertaken any other relevant training, for example in managing challenging behaviours, autism or epilepsy awareness or training in the management of people with brain injuries. They had not, nor had future training been organised for them.

The manager informed us that approximately 60 staff were employed at the service. Training records showed that 23 had completed first aid, 18 food hygiene, 42 moving and handling and 43 Mental Capacity Act training. With regard to training specific to meeting the needs of people, 36 staff had completed brain injury awareness training, 13 behaviour management, 24 breakaway and safe escape techniques, 32 communication, 11 epilepsy, 25 equality and diversity and 27 dysphagia and management of choking training. A training programme was in place but at the time of our inspection there was little management oversight and planning that would ensure sufficient numbers of staff attended courses, including refresher. This was compounded by the staffing levels and vacancies at the service.

The above evidence demonstrated that staff had not received appropriate training, supervision and appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that staff obtained their consent when supporting them. One person told us, "They ask my permission all the time." A relative said, "We have heard them asking for X (family member) consent. They have done an assessment about her understanding and if she could make decisions for herself. There was 11 people and us sat around a table and we discussed what we thought would be best for her".

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. None of the staff we spoke said that they had undertaken recent training in this area despite records stating training had been provided during February and July 2015. However, some did have an understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One staff member told us, "I think the main point of the Act (MCA) is that we all have the capacity to make decisions unless proven otherwise". Another staff member told us, "It's important here is there are people who can't make big decisions for themselves. We help them, along with their families". During our inspection we observed and heard staff ask people's permission before carrying out tasks, such as combing their hair and putting hats back on.

Requires improvement

Is the service effective?

As a result of our previous inspection a compliance action was set (now known as a requirement action) in relation to consent to care and treatment. At this inspection we found that sufficient steps had been taken and the requirement action had been met. For example, one person's records included a detailed mental capacity assessment with recorded best interest decisions that included consultation with the person's representatives. However, we found a new area of concern. One person had an MCA in place for consent to care, the use of bed rails, medication and living at the service. All parts of the assessment had 'N/A' recorded to questions about the person's ability to retain information. There was no evidence of consultation with the person or their representatives. We discussed this with the manager who informed us that the service had used the person's previous placement MCA which was not in accordance with the MCA guidelines.

It is recommended that the registered provider reviews it processes that relate to mental capacity assessment's to ensure they comply with the five principles of the MCA.

Some staff could tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records were in place that evidenced that DoLS applications had been submitted to the local authority authorising body for people as required.

People said that they were happy with the choice of food and drink at the service. People received support to increase their food preparation and cooking abilities in line with their rehabilitation plans. One person told us, "I am supported to make my own meal, I like cauliflower cheese. I am using the microwave to make a ready meal today. The OT had bought the meal; I was involved in choosing what was going to be bought". Another person said, "Food's okay. Chef has asked me what food I like and I do get that. They'll give me something different if I don't like what is on the menu". A third person said, "Good food, sometimes I don't eat it, so I get an alternative". A relative said, "We told the chef X (family member) likes spaghetti hoops and mashed swede with pepper and butter. Two days later this was on the menu for her".

The chef was able to explain the dietary needs of people and their meal preferences. "X loves chicken in curry sauce in a sandwich, so we make that for him." One person was on a diet, she said, "Rather than just saying no you can't have biscuits I remind him about his diet and talk it through with him."

Part of the evening mealtime experience was observed. People were offered a choice of different flavoured pasties, jacket potatoes with various fillings, and one person had a tuna bake. Baked beans, vegetables and onion gravy were available. Where needed, staff sat and supported people to eat. The atmosphere was relaxed and informal with conversations going on between people and staff and amongst each other. There were raised table for those in high / standing wheel chairs.

People said that they were happy with the support they received to maintain good health. One person said, "They (staff) know what they are doing when they support me. I saw the GP last week when I felt unwell". Another person said, "Not seen the optician or chiropodist, but I haven't been here that long. I have seen the OT and SALT." We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of internal and external professionals in the care of people. These included gastrostomy nurses for the care of people with PEGs. The provider also employed on site speech and language therapists, occupational therapists, physiotherapists, vocational and sports and leisure staff. In addition, the provider employed a medical director, part of whose role was to assess people's suitability for care and treatment at the centre.

Good

Is the service caring?

Our findings

People said that they were treated with dignity and respect. One person said, “They always talk to me like I am a human being” and “They respect my personal space when I wish to be on my own”. A second person said, “They cover me up when giving personal care. They knock and wait for a response before coming into my room”. A third person said, “Everything they do they do with respect to me”.

Staff understood the importance of respecting people’s dignity and privacy. One staff member told us, “A lot of the therapy people get is done in private, to make sure they’re protected”. Another staff member said, “I always knock before I go into someone’s room”. Our observations on the day confirmed this. Staff were seen to knock on people’s doors and say who it was before going in. For one person we observed that in addition to knocking on the person’s door staff said who they were and why they were there. A sign on the door recorded that this was what the person wanted before staff entered their room. For another person, staff noticed that their jumper had moved and exposed their stomach. They spoke to the person and told them and asked if they wanted them to pull it down. The person indicated yes, so staff did.

Positive relationships were in place between people and staff. With regard to building relationships, one member of staff said, “We have to adjust our personality to suit them. I can’t come in here in a bad mood. This is like a family here. I care for them as much as I do my own.”

Staff were heard calling people by their preferred name as recorded in their care records and were seen greeting people as they went about their daily routines. People appeared relaxed in the company of staff and friendly banter was heard between people. For example, staff were observed to talk to one person in a really positive way. They talked about hobbies and interests and the conversation flowed like a chat between two friends. When the member of staff left the person they were heard to say, “Nice talking to you” which was a show of respect.

On another occasion a person was seen being moved in their wheelchair by staff down a corridor. Two staff, as they walked past said hello to the person, asked if they was feeling better and that it was really good to see them up and about. This showed respect for the person and that they cared for the individual.

People said that they were supported through a programme of rehabilitation to regain their independence. One person said, “I do what I can do. I try to get out of my bed on my own to promote my independence. Staff have assessed this with me to make sure I can do it safely”. A second person said, “I am supported to make my own meal”. A third person said, “They set goals with me, and I have achieved the majority of them. I know what I want, to be able to move on from here, they listen to this and help advise me on how I can do this”.

We asked staff how they promoted people’s independence. One staff member said, “Rehabilitation is what we do. People aren’t here forever so we need to help them improve their independence”. Another staff member told us, “I think that’s the point of being here. We’ve failed if someone doesn’t leave in a better shape than they arrived”. A third member of staff said, “When people leave they have a little celebration and give a speech, I have to leave and go and have a cigarette as I get upset. The best part of the job is helping people to get better.”

People said that they were supported and involved in making decisions about their care and treatment. People told us that they had been involved in the formulation of their rehabilitation packages and were consulted when changes to their programmes were being made. One person said, “I have a care plan; they go through it with me”. A second person said, “They went through what I wanted. They set goals with me, and I have achieved the majority of them. I know what I want, to be able to move on from here, they listen to this and help advise me on how I can do this”.

Requires improvement

Is the service responsive?

Our findings

Management of staff levels and vacancies impacted on the service that people received. Records and discussions with staff evidenced that relatives and staff had raised concerns about staffing during 2015 and how people had not always received the care and support they needed to meet their individual needs. During our inspection we found that issues remained and that at times people did not receive a responsive service. This included at times, people not having the agreed one to one support they had been assessed as needing, agreed therapy sessions not taking place as scheduled and people unable to go out of a weekend due to no driver being available.

Despite this, people generally felt that there were enough activities offered to entertain and stimulate them. One person said, "I do keep in contact with my relatives. I get to go out for a pint at the local pub. I get to do the activities I enjoy. I am working with the SALT and Dragon software so that I can look for a job". A relative said, "They (staff) went up to Dean City Farm, she loved it. She went to a café as well and staff had the shop make her mash and cheese which she loves". Another person told us that of a weekend there was less to do at the service.

As part of the rehabilitation programme provided at the service each person had a timetable unique to their needs that included therapeutic services. Therapeutic services were planned for weekdays and leisure opportunities were available weekends and evenings. On the first day of our inspection we were informed that there was no SALT available and as a result people who should have received this therapy were being offered an alternative. The service had dedicated therapy rooms which included a physical therapy gym, music room and a fully equipped working radio station. During our inspection people were observed participating in a range of therapeutic sessions and activities. One person was being supported to take photographs as an activity. They told us that this was something that they were particularly interested in.

One person invited us to their room and showed us motivational signs on the walls. These included eight reasons why they wanted to lose weight, and their strengths and positive messages about how others viewed them. The person explained that they had made all of these with their psychologist as aids to meet their individual needs.

People said that the service took action when their needs changed. One person said, "The GP came out when I had a UTI. They acted quickly when I was unwell". A relative said, "X is peg fed. They are getting X to eat with her mouth slowly. Chef does special meals for her as they are trying to reduce the use of the peg. We raised a concern about her eating. Staff got the SALT and put our minds at rest".

We asked staff about person centred care and how they achieved it. One staff member told us, "It's making sure people get the care they need at the time they need it". A second staff member said, "It's an issue here. For example, I knew one person would really benefit from a translator and I mentioned it to management but nothing happened". A third member of staff told us about a person who did not speak English. They said, "Not sure how others are communicating with her. We talk to her relatives as they can speak English." As a result of these comments we looked at the records for this person. These confirmed that English was not this person's first language. Arrangement were in place where an interpreter visited the service on a weekly basis to assist the person to communicate when participating in their therapeutic rehabilitation sessions. Records also evidenced that the service had used the interpreter over the telephone when they wanted to explore a change in the person's physical condition. On the second day of our inspection we were shown a pictorial reference guide for areas that included rehabilitation therapies and were advised that the person used this to communicate when an interpreter was not present. Although measures had been put in place in order that the person could communicate their needs and wishes this had not been clearly cascaded to staff that we spoke with.

People's care records did not always contain detailed information about people's family, social histories, cultural and religious needs. The service used a tick box form for identifying needs. Despite this, people said that their needs were met in these areas. One person said, "I don't eat pork, staff are aware of this. I do get to practice my faith". A second person said, "They kind of know me and my cultural needs are supported".

People's bedrooms were very personalised with family photos, ornaments, game systems and items that reflected people's interests. For example, one person had a love of motor bikes so had posters up in their room about them.

The manager informed us that the provider had assessed that the building was not fit for purpose. In response to this

Requires improvement

Is the service responsive?

the provider intended to close the service at the current location and to build a purpose built service at another location it operated. Consultations have occurred with staff and plans had been drawn up. The manager explained that the provider aimed to have the new building completed by 2017. We were also informed that due to the timescale for this to take place the provider had released funds in order that repairs to bathrooms at the service were responded to.

People said they felt able to express concerns or would complain without hesitation if they were worried about anything. One person said, "I have not needed to complain. I know the channels and chain of command. I think they would listen to me, I don't hold back if I was unhappy". A second person said, "I would go to the manager, but I have not needed to. I think they would listen to me". a third person said, "I know how to complain, but I haven't needed to"

The services complaints procedure was displayed at prominent points throughout the building in order that people could refer to this if needed. Records were in place that showed that where concerns or complaints had been raised, these had responded to these on an individual basis, either by email or letter.

Inadequate

Is the service well-led?

Our findings

Discussions with staff and examination of records confirmed that there had been a change to the staffing structure and this in turn had altered staff roles and responsibilities. This had not been managed well, had affected staff morale and the smooth running of the service. Roles and responsibilities within the service were unclear to staff and they were unsure who they were accountable to and what they were accountable for. One member of staff said, "I don't think we are always listened to. We read through the care plans. Rehab assistants used to make the care plans, but nurses do it now, even though we are the ones that give the care to the person". A second member of staff said, "Staffing is affecting everything. That's why people are leaving. I've spoken to X (member of staff with a management responsibility) and felt that I've not got any response. So you just end up feeling like you can't be bothered. I also raised it with the previous manager but she was as bad. It feels like we are all losing our passion and families are going to pick up on this which is not good". A third member of staff said, "It's changed to more of a medical unit. I don't know my role anymore. I've not been told what's expected of me. The changeover has been poor. I don't feel valued".

The manager told us that the staffing structure had been changed as the service was now admitting people with more complex health needs. As a result, the provider was applying for higher funding from placing authorities. In order to obtain this the staffing structure had needed to change and included the employment of a consultant and having nursing staff on each shift. The service had also employed a head of nursing. The medical director told us that there had been no specific date for transition to nursing care and that this started when the head of nursing was recruited in May 2015. Discussions with staff and examination of records confirmed that prior to May 2015 people resided at the service who had nursing needs. We were informed that these were managed by community nursing services such as district nurses. Since being registered with us the location has been registered to provide nursing care. The provider should have applied to change their registration but had not done so.

The services had a Statement of Purpose which was dated in 2013. This made reference to the registered manager who had left the service in September 2015. The Statement of Purpose should have been updated and CQC should have been informed of this but this had not happened. Both the examples above were breaches of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

Quality assurance systems were in place to help ensure quality standards were maintained and legislation complied with. However, these had not always identified areas that required improvement, had not always been completed and did not always mitigate risks to people. A safeguarding audit was completed in 2014 and 2015. Actions were noted but had not been signed off or reviewed. A mock inspection was completed in April 2015 which resulted in a number of recommended actions. It was not recorded if these recommendations had been completed or actioned. There had been an audit of medicines management in July 2015, but none since. No external medicine audit had been conducted. Therefore, it was not possible to identify and address errors, trends and issues in order to maintain the safe and effective management of medicines.

A building fire risk assessment was completed by the provider's health and safety advisor and reviewed on in October 2015 by the facilities manager. There were a number of outstanding actions which had not been followed up or signed off as actioned despite being recorded as high priority. These included ensuring appliances which pose higher risk of fire like shredders and kettles are tested more often, and improving housekeeping and provide additional storage for areas / offices where dangerously high amounts of flammable materials had accumulated.

Audits of care records, falls and nursing care had not taken place on a regular basis. A member of staff responsible for completing these told us, "There were no care plan audits, falls audits catheter audits at all when I first came here. I did one since being in post but I have not had time to do more and there has been no one to delegate to".

Records were not always accurate. An incident report stated that a grab rail had come away from a wall and resulted in a person falling backwards. The maintenance manager told us that the incident report was incorrect and that the equipment that broke was a drop down rail which

had been repaired. Accurate and up to date staff rotas were not available that reflected who had been on shift and in what capacity so we were unable to establish the staff that were working.

The above evidence demonstrated that robust systems were not being operated to assess, improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An audit of complaints had not been completed and as a result an analysis had not been undertaken to identify trends or to ensure action was taken to improve services and mitigate risks to people. We identified seven complaints that should have resulted in statutory notifications to CQC having been submitted. The manager confirmed that these had not been submitted. As a result CQC was unable to monitor that appropriate action had been taken to ensure people received safe and appropriate care and support. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The majority of staff expressed concern about management of the service and communication. One member of staff said, "I have to say that I feel quite disempowered. I sometimes have to ask the nurses about people as we don't get a handover, like the nurses do. I think that would be a good idea". Another staff member said, "There's been a marked culture change over the past year. I think the rehabilitation assistants feel they've been stripped of all their responsibilities and the things that make the job worthwhile. I don't think it was necessary to do that, particularly as there are a few new nurses here. I must say I find that worrying as there are more senior nurses leaving". A third member of staff said, "I'm not sure what the purpose of this place is now and I think a lot of staff think that. A lot of new people coming here have a lot of nursing needs and we wonder if that's the best way".

Staff meetings had taken place but some staff were not aware of these. One member of staff said, "I've never been invited or attended any". Another said, "I know they have them but I've not been made aware of them". Since changes in the staffing structure had taken place 15 minute meetings were held every morning that the head of each department attended. A member of staff explained during these meetings therapy sessions were discussed and information shared between departments.

In addition to making changes to the staffing structure at the service there had not had a registered manager since 30 September 2015, however cover had been provided since 01 October 2015. A new manager had been recruited and was due to commence employment in January 2016. The registered manager from the providers other service was overseeing the service and shared her time between both of the providers locations. Staff said that they felt better supported since the interim manager had been covering the manager's position. One member of staff said, "The management is improving. X (manager) walks around seeing what is going on a lot more than the old manager, she is quite good."

People said that the provider sought their views on the service. One person said, "We have meetings. We talked about the refurbishment and were asked for our views. If I had an idea I'm sure staff would listen and look into it". A second person said, "We have house meetings, talk about food and trips out. They listen to us and make changes. They gave us bigger portions on the food when we raised it". A relative said, "They haven't really asked for our feedback, but we can't see anything they could improve".

As part of the planned closure of the service and transfer to a new location people were invited to a meeting to discuss this with the chief executive of the organisation. People were asked for their views about the new facility and we were informed these were being considered. For example, a hydrotherapy pool and occupational therapy kitchen to be on site. Customer satisfaction surveys were also sent to people in January 2015; those people that responded indicated that in general they were satisfied with the service provided.

People's views of management of the service varied. One person said, "I think it's well organised here; communication is good but could be fine-tuned a bit. I would say they do make improvements when we suggest them". A second person said, "I think it's very well run. We have had a change in manager recently. The CEO comes and visits and talks to me". A third person said, "I think it is well led here. I have met the CEO".

On the first day of our inspection we asked about 'duty of candour' and its relevance to the care and support of people living at the home. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on

Inadequate

Is the service well-led?

behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents .The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. None of the staff members we spoke with were aware of this regulation and were unable to describe its relevance and application. On the second day of our inspection we were shown a policy about duty of candour and the manager explained that she was in the process of making staff aware of this. The manager demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection.

The manager acknowledged that the service had been going through times of change and that this had impacted on staff morale, communication and the running of the service. as a result of the feedback we gave at the end of our inspection we received written confirmation from the chief executive that the service would not admit any new people until the issues had been resolved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not ensured robust systems and processes had been established and operated to prevent abuse of people. 13(1)(2)(3).**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The registered person had not kept under review the Statement of Purpose or provided written details of changes in service to CQC. 12(1)(2)(3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified CQC of all incidents including any abuse or allegation of abuse. 18(1)(2)(e).**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of staff to safely support people with their needs. Staff did not receive sufficient support to fulfil their roles and responsibilities.

The enforcement action we took:
A formal Warning Notice was issued on the registered person that told them they must make the required improvements by 14 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people were not always managed safely. Timely action was not always being taken to ensure the environment and equipment was safe.

The enforcement action we took:
A formal Warning Notice was issued on the registered person that told them they must make the required improvements by 06 January 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Robust systems were not being operated to assess, improve the quality and safety of the service. Audits of care records, falls and nursing care had not taken place on a regular basis. Records were not always accurate. An audit of complaints had not been completed and as a result an analysis had not been undertaken to identify trends or to ensure action was taken to improve services and mitigate risks to people.

The enforcement action we took:
A formal Warning Notice was issued on the registered person that told them they must make the required improvements by 15 January 2016.