Partnerships in Care (Oak Vale) Limited

Oak Vale Gardens

Inspection report

1C The Green
Liverpool
Merseyside
L13 4BX

Tel: 01512202708

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 October 2016. The last inspection took place on 6 May 2014 and the registered provider was compliant with the regulations in force at that time. In September 2015 the service was registered by Partnerships in Care (Oak Vale) Limited with the Care Quality Commission (CQC) and this will be the first inspection since this registration.

Oak Vale Gardens is an extended rehabilitation facility which provides accommodation and support for 18 adults with an acquired brain injury and complex health and social care needs. The purpose built facility offers accommodation in easily accessed grounds with car parking facilities.

The service is a two storey building, with the upper floor being divided into two units; Unwin unit provided support for more able bodied people, whilst Stephenson unit supported people with more complex needs. Unwin and Stephenson had nine bedrooms each (all en-suite), and each unit had a quiet lounge used mainly by visiting families, a main lounge and a separate dining room. Each unit had a communal bathroom where people could access assisted bathing and shower facilities. All but four of the bedrooms had direct access onto the garden areas. We found there were a total of 17 people using the service when we inspected.

The registered provider is required to have a registered manager in post and there was a manager who had registered with the Commission and had been in post since October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following robust recruitment and selection processes.

Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. Until the service was fully staffed there was the occasional use of agency staff, but the same staff were booked to aid the continuity of care for people using the service. Staff did not appear rushed on our inspection and there was a good atmosphere in the service.

Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

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

The registered provider had an induction and training programme in place and staff were receiving regular

supervision. People were confident in the staff skills and knowledge and said they received care and support.

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

The main focus of the service was rehabilitation so people received regular therapy sessions from the multi-disciplinary team including physiotherapy, occupational therapy, speech and language therapy and had input from the psychologist based at the service. People had access to a range of low key social activities and events within the service, which the majority of people were satisfied with.

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

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

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people and relatives about the care and support offered by the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

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

Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

Is the service effective?

Good

The service was effective.

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

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

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

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience when supporting people. Clear explanations were given to people as tasks were carried out by the staff.

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

Is the service responsive?

Good

The service was responsive.

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

People had access to a range of therapy sessions to aid their rehabilitation and staff carried out a daily exercise regime with each person. There was also a range of low key activities in place.

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

Is the service well-led?

Good

The service was well led.

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

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

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

Oak Vale Gardens

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 6 October 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

As part of the inspection process we contacted the local authority safeguarding adults and commissioning teams to enquire about any recent involvement they had with the service. We also contacted the Clinical Commissioning Group (CCG) for Merseyside. None of the teams had any concerns about the service.

At this inspection we spoke with the registered manager, deputy manager and the service director. We also spoke with four staff members and then spoke in private with one visitor and five people who used the service. We carried out observations on both units of the service and walked around the whole building.

We spent time in the office looking at records, which included the care records for three people who used the service, the recruitment, induction, training and supervision records for three members of staff and other records relating to the management of the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service. Comments included, "All the staff are lovely" and, "I feel safe here." One relative said, "I am satisfied that [Name] is kept safe as the exterior doors are key coded and the codes are changed regularly. [Name] also has bed rails and protectors to keep them safe when in bed." Staff told us they thought people were safe and they had no current concerns about safety.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The two medicine rooms and fridge temperatures were taken each day and these were within the minimum and maximum advised temperature range. People said their medicines were administered on time and were always available when needed.

The qualified nurse on each unit was the designated person who had overall responsibility for the medicines and the medicine policy and procedure was accessible to the staff and included best practice guidelines. The nurse communicated effectively with people, even those who could not say if they were in pain or were in need of support . The nurse told us, "We know the people who use the service. We look at their posture, their facial expressions and the majority of people can use gestures to let us know how they are feeling." Staff had received medicine training and we saw evidence of up to date competency checks on staff practice.

Checks of the controlled drugs found these to be appropriately stored and recorded. Controlled drugs are those medicines required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

We saw in the medicine administration folder that each 'as and when required' medicine (PRN) had a written protocol and a care plan to instruct staff as to when, why and how each medicine should be administered.

One relative told us that they asked staff to let them know each time their loved one received medicine to reduce their agitation as they were concerned about them becoming over medicated. They said, "It has really eased my mind in that the staff do tell me if [Name] has needed the sedative, but this has been very occasionally over the past four months. I am satisfied that the staff only use this as a last resort. Even the consultant knows I want to be informed about [Name's] medicines and it is discussed at their reviews with me." This demonstrated that the service and staff worked collaboratively with people and families and that PRN medicines were used therapeutically and only administered when really necessary.

We found that the service had systems in place to manage safeguarding incidents and staff training records evidenced that staff were trained in safeguarding adults from abuse. Staff demonstrated knowledge of what

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

There had been only one instance in the last year when the safeguarding alert forms had been completed. This was completed appropriately and in a timely way. The local council safeguarding team were sent the correct information and an internal investigation had been completed. The registered provider had followed their disciplinary procedure and a member of staff left their employment. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. For example, two of the bedrooms were equipped with specialist 'Hi/Lo' beds and mesh sided bed rails as the people had been identified as a high risk of entrapment from the normal bed rails and bumpers, and at risk of falling out of bed.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. One person told us, "The staff leave me with the bed remote control and the call bell so that when I am in bed, I can alter my position and they attend quite quickly if I need anything." The care files we looked at highlighted where people required one to one support when in their wheelchairs and we saw evidence of 15 minute observations taking place for other people in their bedrooms. The relatively few incidents occurring in the service indicated that these safety measures were effective.

Discussion with the registered manager indicated that at the time of our inspection there were staff vacancies for one night nurse, one band five speech and language therapist (SALT) and one ancillary staff. We saw that over the last three weeks agency staff had been covering the night time nursing hours, but we were told that there was always an experienced nurse on duty as well. Checks of the last four weeks of duty rosters confirmed this.

The staff team on each unit comprised of a qualified nurse and three support assistants over the 24 hour period. The multi-disciplinary team (MDT) comprised of a psychologist, physiotherapist, occupational therapists and speech and language therapists. The registered provider also contracted out for physiotherapy and additional occupational therapy hours using the same group of staff Mondays to Fridays. The director of the service told us that the Clinical Commissioning Group (CCG) funded each person for a set amount of therapy based on their needs. The registered manager told us that the service used the Rehabilitation Complexity Scale (RCS), which described the level of support each person using the service needed for either basic self-care or to maintain their safety. It was used to check people's dependency levels and staffing levels.

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

meet people's assessed needs.

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

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

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

The staff we spoke with had good knowledge of infection control including use of personal protective equipment or PPE (aprons and gloves). We observed this being used appropriately during our inspection. We saw that in the treatment rooms there were individual boxes of clean syringes and other equipment used when staff administered nutrition to some people using a percutaneous endoscopic gastrostomy (PEG) feeding tube. A PEG is a procedure that takes place for a person who cannot take nutrition orally. A tube is inserted through the person's abdominal wall and into the stomach, through which nutritional fluids can be infused.

Infection control audits were carried out twice a year, with one being completed by the NHS infection control nurse, and included an action plan for the outcomes noted as needing improvement. These were signed off by the registered manager when completed. All areas within the building were clean, well lit, spacious and free from clutter. We saw that the bespoke wheelchairs for each person were cleaned and labelled after each use so staff knew they were ready for use. The service had policies and procedures with regard to infection control, including colour coded mops, buckets and cleaning cloths for different areas of the service and these were readily available for the cleaning staff to use. All areas we looked at, including the sluice room and bathing facilities were clean, tidy and there were no malodours around the service.

Good

Is the service effective?

Our findings

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

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

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

Staff confirmed they completed an induction which orientated them to the service and covered corporate information such as employment issues, policies and procedures and layout of the building. We were told that new staff were allocated a mentor and they shadowed more senior staff and the multi-disciplinary team (MDT) for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork. We saw that the deputy manager and the speech and language therapist (SALT) completed competency checks on staff. For example, nurses had regular checks carried out for medicines and tracheostomy care and the competency records were made available for our inspection.

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

Staff received direct supervision from their line manager and supervisions were carried out every two months. Staff told us that supervision was a two-way process and they felt confident about raising any work issues and these were listened to and acted on. We were given access to this documentation during the inspection. Senior therapists received regular clinical supervision from a consultant therapist who worked outside of the unit.

People in Oak Vale Gardens received support and care from the multi-disciplinary team (MDT) on a weekly basis and, in agreement with the local Clinical Commissioning Group (CCG), two rehabilitation consultants from the North West specialist Neuro-rehabilitation centre (Walton Centre) visited the service on the first and third Saturday of each month to hold a satellite clinic and review all the people as needed. This meant people using the service did not have to travel to external appointments to have their progress reviewed and this was less stressful and exhausting for individuals. One consultant also held a ward round every

Wednesday evening and used a laptop funded by the CCG to document their recommendations directly onto the EMIS system. EMIS is a connected healthcare software programme linked to the NHS and GP services. The consultant's recommendations were followed up by the local GP's as they remained ultimately responsible for the people in the service. Care plans were updated by the therapy team. Any concerns were documented. Issues with people's diet were raised with the SALT and the community dieticians. This indicated there was good partnership working between all medical teams inputting to people's care, which meant people had less delay in receiving appropriate treatment and care.

Communication between families and staff was good. One visitor told us, "I was concerned that [Name] had not been to see the dentist for some time and their gums looked inflamed. I told the staff I was concerned that [Name] may have gingivitis and could they organise a dental check up. I then went away on holiday. I rang up during my holiday and they said that [Name] had just seen the dentist and everything was okay." This demonstrated that the staff listened to families and took action to make sure people's health and welfare was maintained.

Since November 2015 the CCG had funded additional medical capacity within the service so that GP's from the Old Swan medical practice now came into the service twice a week on a Monday afternoon and a Friday morning to review people's medicines, sort out any prescriptions where needed and physically assess individuals. The people benefited from this by having good access to their own GP and the practice nurses who delivered flu vaccinations and monitored people's long term health conditions such as diabetes and high blood pressure. The staff in the service also benefitted as best practice guidance was disseminated from the lead professionals and hospital link people down to the nurses and support workers.

The Physiotherapists, Occupational Therapists and SALT had a well-equipped dedicated area to work within. The therapists had a shared office facility which promoted good inter-professional working. All the staff interviewed said that the different professions worked well together. There was evidence in the care files that information was being shared between the different professions involved with people using the service. The psychologist had their own files for people that were kept confidential, but we saw that the MDT also wrote notes within the care files for the nurses and support workers to follow. The therapy team were using well established measures to monitor client progress such as Goal Attainment Scaling (GAS). This meant staff established a baseline of needs for each person and then looked at their progress. The therapy team wrote out action plans for the person and care staff to follow and their progress was reviewed every month. The MDT completed an assessment of each person every 12 weeks looking at activities of daily living and rehabilitation progress with each part of the team inputting to the assessment and giving the person a score. These assessments were used as part of the three monthly reviews with the families, person using the service and the commissioners.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that two people who

used the service had a DoLS in place. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

There was evidence in the care files that the mental capacity of people was being considered when there were concerns about someone lacking capacity to make a particular decision. The clinical psychologist told us that they were responsible for carrying out the MCA assessments, DoLS assessments and organising Best Interests Meetings (BIM) for people using the service. They told us that they liaised with the families and this was confirmed by the relative who spoke with us. The psychologist carried out cognition assessments and monitoring, did orientation work with individuals and produced staff guidelines and strategies for managing people's agitated and distressed behaviours. We saw in the care files we reviewed that appropriate behaviour management plans were in place. Part of the psychologist's role was to meet with families and help them work through their emotions such as grief and anger. They also strived to help families understand more about acquired brain injuries and what their relative may be going through.

The staff explained how they had completed Management of Actual or Potential Aggression (MAPA) training to help them use safe and effective physical interventions to manage more challenging and aggressive behaviour which people exhibited with from time to time. They told us they used specific charts to document any agitation and used different techniques to calm people for example, all the bedrooms were designed to be a low stimulus environment including light and noise reduction. There were no records to indicate that physical restraint had been used in the last six months and staff said none had taken place.

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

We discussed the menus with the chef. The service used an external company called Apetito to provide the meals served to people. These meals were specifically fortified or enriched to meet people's needs. For example, the registered manager said where people were only able to eat a small quantity, it was possible to ensure that the meal contained enough calories to meet their nutritional needs. We were aware that a number of people using the service were nil by mouth due to their health conditions and problems with swallowing. These individuals received their nutrition via a PEG. On admission to the service the SALT team assessed people for safety of eating and drinking and the appropriate consistencies to keep them safe; and the community dietician completed a nutritional assessment if required. One person who used the service told us, "I do not always like the food we are given, but I know that I need to start eating and drinking again properly so that I can have my PEG removed."

Other people who spoke with us said the meals were nice and they enjoyed eating them. People were also able to prepare their own meals in the satellite kitchens as part of their therapy programme to regain their daily living skills. A lighter meal was served at lunch time due to people taking part in rehabilitation treatments soon after. The evening meal was more substantial and included cakes and pudding options. People made their choices around meals on a daily basis and the menus operated on a four week cycle.

Good

Is the service caring?

Our findings

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

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

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

We observed that staff displayed kindness and empathy towards people who lived in the service. Staff spoke to people using their first names and people were not excluded from conversations. We saw that staff took time to explain to people what was happening when they carried out care tasks and daily routines within the service. The relative who spoke with us said, "It is marvellous to see that all the staff continually talk to [Name] when they are in their room or carrying out tasks. They explain every time who they are, where [Name] is and what is going to happen. I am not sure that [Name] understands what they say, but is reassuring all the same."

One person told us, "The staff are lovely and caring here." Care plans were person specific and people were given choice about what they wanted to do and when. Staff told us that care plans covered dignity, privacy and respect. Each person had their own room with washing and bathing facilities. In discussions, staff had a good understanding of how to promote privacy, dignity, choice and independence. They said, "We close doors and curtains and gain consent for tasks. We always knock before going into a person's room or bathroom as a number of people like some privacy at times. Everyone has different preferences and routines, so it is important we listen to what they want from us and ensure they have the opportunity to make their own choices." This was confirmed by one person who used the service. They told us, "I get time to spend by myself; staff always knock on my door and wait for permission to come in." One visitor told us, "I am always asked to leave [Name's] room when the staff are giving them personal care. This shows that the staff are considering [Name's] privacy and dignity, because prior to their accident they would not have

wanted me in the room with them."

One relative spoke positively about the service. They told us their family member had good and bad days now with epileptic seizures and agitated behaviour at times. Their family member had extremely limited communication abilities, but they said they could see some small improvements in their condition. The relative told us, "I was extremely nervous and worried about [Name] coming into the service, but I have found the staff to be friendly, helpful and caring and I can go home and have peace of mind that [Name] is being well cared for. [Name] is maintaining their health and wellbeing. The staff are constantly trying new things with care and rehabilitation, they maintain [Name's] physical needs and carry out positioning and passive stretching."

Unlike most care homes this service operated much like a hospital setting in that there were set visiting times Monday to Fridays of 18:00 to 20:00. These depended on each person's rehabilitation plans developed by the MDT. The registered manager explained that the limited visiting hours gave people time to complete their treatment and have rest periods without interruption from visitors. However, there were no prescribed times for visiting on a weekend. One relative told us, "The family take turns at coming to visit [Name], but if I am working on an evening the staff will let me visit at another time when [Name] is not at therapy." This showed that the service recognised the need for people to maintain relationships with people who are important to them.

Staff told us they enjoyed working in the home. They said they had a good range of equipment to help them meet people's needs and that the environment was safe and secure. One member of staff told us, "I like it here, it is nice to look after people who are getting better."

People had detailed care files. Their past medical history was recorded and any personal information was retained in the main care files which were kept locked away in the nurses office. This helped maintain confidentiality.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs. The care files we looked at were written in a person centred way, with an emphasis on rehabilitation and each person being encouraged to be as independent as possible. Essential daily care planning information was kept in a main file in the nurses office, and another file known in the service as the 'Guidelines' (Red file) contained photographs and clear instructions on how to move and assist each person and was kept in their bedroom. The red file for one person included an occupational therapy assessment for use of the hoist and sling. It also referred to the use of sequencing cards (picture cards) that staff used to help the person complete tasks such as making their own breakfast. Families had access to these, rather than the full care file. Information from these was shared as requested and appropriate i.e. with patient consent where possible.

The registered manager told us that all referrals to the service were taken to the MDT meeting each Monday and discussed. As the main commissioners were the six Merseyside Clinical Commissioning Groups who funded 16 of the 18 beds available, the initial assessment of new referrals was carried out at the Walton Centre. The registered manager told us that the service was defined as an extended rehabilitation facility and people on average stayed with them for between 18 and 24 months. Depending on the progress made by individuals they would be eventually discharged to their own homes or would move onto another care facility for long term care.

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

One relative told us, "I am able to read [Name's] care file when I wish to. The staff involve me in their care planning and I can make suggestions about their wishes and choices as they cannot speak up for themselves. I have attended their three month reviews and I get to discuss [Name's] treatment with the professionals present. I get emotional at times, but the staff give me every support and I have spoken with the psychologist who is helping me work through the emotional turmoil that [Name's] accident has left me in." This demonstrated that staff were supportive and included families in people's everyday care, whilst helping them come to terms with their change in circumstances.

Discussions with the registered manager, MDT members and staff indicated that they were all enthusiastic about moving the service forward using best practice to improve the experience of people using the service. For example, Oak Vale Gardens had recently seen the arrival of a balance re-trainer, which could be used by a number of the people using their service to help achieve their rehabilitation goals. In therapeutic circles prolonged standing as part of a daily routine is beneficial. The re-trainer can be used for lower level people as well as more high functioning individuals and people can be hoisted from a sitting position or step into

the standing frame and then be supported with knee block, foot stirrups and/or a pelvic support. Since using the balance re-trainer the service had seen improvements in postural control and awareness of mid line, regulation of blood pressure, increase of movement, reduced fear of falling and improvement in proprioception (The ability to sense stimuli arising within the body regarding position, motion, and equilibrium).

One person told us they were bored as they did not have enough to do to engage them. There were daily therapeutic activities taking place, but when these were completed people had time on their hands and little to do. This had been recognised by the registered manager who told us the clinical basis of the service meant it did not place much emphasis on social activities as the point of the service was to improve people's independence and it was not a care home. At the moment activities in the service were low key with staff carrying out activities with individuals when time permitted. People did have access to television points and Wi-Fi in their bedrooms and one person told us that they spent time in an evening on their i-Pad or watching television. Other people enjoyed spending time in the gardens when the weather permitted this. People took part in life skill sessions in the small kitchens on each unit and we saw that people were sat in the lounge areas chatting and watching television. People had access to a selection of books and DVD's within the service.

People and relatives knew how to make a complaint and the registered manager listened to these and took appropriate action to improve practice within the service. We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. There were posters about making a complaint near the lift on each unit, the information was presented in a pictorial and simple word format making it easier for people to read and understand.

One person told us that the staff and the registered manager were easy to talk with, they listened to their concerns and were quick to respond where needed. No one who spoke with us had any concerns at the time of our inspection.

Good

Is the service well-led?

Our findings

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

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

All of the members of staff who were interviewed said that they received regular supervision and felt supported by the management and that both the registered manager and the deputy were approachable. They also told us that it was a good place to work and one member of staff said, "There is good leadership from the higher management and a high quality of care being provided. I think people are well cared for and I would not change anything."

The registered manager had come into post in October 2015 and registered with the CQC in March 2016. At the time of our inspection they were busy ensuring that documentation within the service was being changed over from that of the old provider to those of the new provider (Partnerships in Care). This included new care files and other care records, policies and procedures, training schedules and systems. We saw that old files had been archived and were stored securely in the service until they were taken to another external secure storage facility, in line with the registered provider's data protection policy.

All of the staff said they felt supported by their colleagues and there was a clear line of management from the top down to the support staff. Staff told us they felt they could be open and honest about care and could speak to their line manager if they had any issues. Staff told us they had the opportunity to attend quarterly meetings and said, "These give the team a chance to air any views and we feel 'listened to' with regards to the meetings." We were given copies of the meeting minutes to look at.

We sat in on one of the daily briefing sessions held with the registered manager, deputy manager and nurses from the two units. They discussed what was happening within the service, how people were progressing, what appointments were taking place and looked at staffing levels and the management of the service. This demonstrated that there was good communication at the senior level within the service and that quick action was taken to ensure the service ran smoothly.

The registered manager told us that people were sent questionnaires at the end of their stay in the service.

The director for the service told us that this process was being changed so that surveys were sent to people on-line; this would mean staff within the service were not involved in the process and therefore it would be more impartial. We were able to see some of the surveys returned in June 2016; the feedback from these had yet to be analysed by the registered manager, but on the whole were very positive about the care and service.

The registered manager was fully aware of the need to maintain a 'duty of candour' (responsibility to be honest and to apologise for any mistake made). Due to the very few incidents in the service there had been no need for this to have been used in the last year. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and then sent onto the director who included the results in their presentation to the registered provider. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

The registered provider's annual report for 2014/15, stated that the vision for the service was to have specialist rehabilitation care, underpinned by best practice, research and education to optimise patients' rehabilitation outcomes. The quality account for the registered provider in 2015/16 said that their mission was to ensure that the patient was at the forefront of every aspect of their care delivery from the moment they came into contact with the services. Our observations of the service indicated that the registered manager and staff had these as the focus of the care they gave to people and that they were determined to improve the quality of life for those who used the service.