Priory Rehabilitation Services Limited

The Priory Hospital Heathfield

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected The Priory Hospital Heathfield on the 25 June 2018. This was an unannounced inspection.

The Priory Hospital Heathfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Priory Hospital Heathfield provides accommodation with personal and nursing care for up to 30 adults with an acquired brain injury. The service is divided into two units. Boyce unit provides long term nursing care and support for people who live with conditions such as Huntington's Chorea. Holman unit is a unit for people with an acquired brain injury for specific behavioural rehabilitation. People were living with a range of care and nursing needs, many people needed support with all of their personal care, and some with eating, drinking and mobility. Some people on Holman unit were more independent and needed less support from staff. There were currently 12 people who lived at the service. People's accommodation and communal areas were provided on the ground floor.

The Priory Hospital Heathfield is owned by Priory Rehabilitation Services Limited.

At a comprehensive inspection in August 2016 the overall rating was Inadequate and the service was placed into special measures by the Care Quality Commission (CQC). We undertook an inspection in March 2017 to see if the necessary improvements had been made. We found that significant improvements had been made and that the breaches of regulation had been met. We ascertained at that time that further time was needed to embed the improvements made in the safe and well led questions to ensure the improvements were sustained and that the overall rating was requires improvement.

This inspection found that the service had sustained the improvements necessary and achieved an overall rating of good. We will review the overall rating of good at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been sustained.

There was a registered manager in post. 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 were content and relaxed with staff. They said they felt safe and there were sufficient staff to support them. One person said, "Very safe." Another said, "Excellent facility for me to get better." When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. Risks associated with the environment

and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with an acquired brain injury, multiple sclerosis, Huntington's Chorea, epilepsy, diabetes as well as specific mental health disorders, such as Korsakoff disease and dementia. They also received training in managing behaviours that challenge. Formal personal development plans, including two monthly supervisions and annual appraisals were in place. Staff were supported to become to undertake further training.

The provider assessed people's capacity to make their own decisions if there was a reason to question their capacity. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people could give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People chose how to spend their day. Activities were mixed and people could choose either group activities or one to one. People were encouraged to stay in touch with their families and receive visitors. The provider had sent CQC notifications in a timely manner. Notifications are changes, events or incidents that the service must inform us about.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns. The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

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 Priory Hospital Heathfield was safe.

There were systems in place to make sure risks were assessed. Measures were put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

The Priory Hospital Heathfield remains effective.

Mental Capacity Act 2005 (MCA) assessments were completed routinely as required and in line with legal requirements.

People were given choice about what they wanted to eat and drink and were supported to stay healthy.

A multi-disciplinary approach to care ensured people had access to health care professionals as needed.

Staff had undertaken essential training and had formal personal development plans, such as one to one supervision.

Is the service caring?

Good

The Priory Hospital Heathfield remains caring.

People's dignity was protected and staff offered assistance discretely when it was needed.

Staff provided the support people wanted, by respecting their

choices and enabling people to make decisions about their care.

People were enabled and supported to access the community and maintain relationships with families and friends.

Is the service responsive?

Good

The Priory Hospital Heathfield remains good.

People's preferences and choices were respected and support was planned and delivered with these in mind. People told us that they could make everyday choices, and we saw this was promoted during our visit.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint and these were appropriately responded to.

There were meaningful activities for people to participate in as groups or individually to meet their social and welfare needs

Is the service well-led?

Good

The Priory Hospital Heathfield was well led.

A quality assurance and monitoring system was in place. The registered manager used this to identify areas that could improve and continually drive improvement.

Feedback was sought from people, staff and visitors through regular meetings. Visiting health professionals told us that the staff worked well with them and listened to advice.

Notifications were sent in to ensure CQC was up to date with incidents that could affect the services provided.

Staff were aware of their roles and responsibilities and felt all the staff worked well together as a team.

The Priory Hospital Heathfield

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 checked 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 the 25 June 2018 and was unannounced. The inspection team consisted of an inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service, including safeguarding's and notifications which had been sent to us. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 6 people living in the home and three visitors. We spoke with nine staff including the registered manager, occupational therapist, physiotherapist, speech and language therapist,, deputy manager, 4 care staff, two registered nurses and two chefs.

We observed the care and support provided and interaction between people, visitors and staff throughout the inspection. We observed medicines being given out and looked around the home.

We looked at a range of documents related to the care provided and the management of the home. These included four care plans, medicine records, three staff files, accident/incidents, complaints and quality assurance audits.

We asked the deputy manager to send us copies of the training records after the inspection These were sent to us as requested.

Good

Is the service safe?

Our findings

At the last inspection this key question was rated requires improvement. This was because time was needed for staff to embed safe medicine practices. At this inspection we found the management of medicines was safe and effective and the rating had improved to Good.

People told us that they felt safe living at The Priory Hospital Heathfield. Comments from people included, "Very safe, the staff are obviously well trained, I trust them," and "I have no worries here, plenty of staff around." We were also told "They work very hard,

Appropriate steps had been taken to ensure that there were measures in place to keep people safe. Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies, swallowing difficulties and how they took their medicines. MAR charts indicated that medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered correctly. People told us they received their medicines on time. One person told us, "Always get my pills when I need them." There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol and anti-convulsion (seizure) medicines. Records had been completed with details of why they had been given and if it was effective in relieving the pain or the seizures.

People's medicines were securely stored in a clinical room and they were administered by registered nurses. We observed staff giving people their medicines and saw medicines were administrated safely and staff signed the medicine administration records after they gave them to the person. The clinical rooms on both units were clean and well organised. All medicines were stored correctly and at the correct temperature. There was a clear audit trail that defined what action was taken following medicine errors, such as medicine updates and retraining and competency tests. When necessary, medicine errors had been reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. This meant it had been disclosed to the individual or their next of kin, an apology offered and an action plan discussed to prevent a reoccurrence. This ensured as far as possible lessons had been learnt. Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care.

When people had accidents, incidents or near misses these were recorded on specific forms. We saw the information recorded detailed the actions staff took to ensure people were supported appropriately. These were discussed with staff to ensure people were provided with the support they needed to keep them safe and to look at ways to prevent recurrence. Accidents and incidents were reported to the local authority in line with safeguarding policies. The accident and incident audit looked at times, locations and staffing and analysed the results to gain insight into possible causes and ways to prevent a reoccurrence. This assured that lessons were learned and improvements made when things went wrong.

People were protected from risks associated with their health and the care they received. The staff team

assessed risks to people's personal safety and devised plans to minimise those risks. Risk assessments for health-related needs were in place, such as skin integrity, diabetes, seizures, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, care plans contained information about people's skin integrity alongside the risk assessment (waterlow) to identify people's individual risk to pressure ulcers. Where people's risk assessment identified any risks these were managed accordingly. People had a preventive management plan such as using pressure air mattresses, sitting pressure relieving cushions and turning charts. It was evident the staff followed these guidelines to maintain people's health and wellbeing.

Equipment used to minimise the risk of skin damage such as pressure relieving mattresses and cushions were checked daily by staff. This ensured they were on the correct setting for the individual. We found all were correct and working. People's care documentation and risk assessments reflected the lifting equipment and size of sling to be used. People had their own personal sling which reduced the risk of cross infection. Due to some people complex health needs which included involuntary muscle movement, bed rails were required to keep them safe. The risks associated with the use of bedrails had been assessed and complied with safety guidelines as recommended by The Health and Safety Executive.

Risks associated with the safety of the environment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. Staff followed a cleaning schedule and used appropriate personal protective equipment to help protect people from the risks relating to cross infection. The systems in place ensured the service was kept clean, tidy and odour free. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan.

Staff received safeguarding training and understood their responsibilities for keeping people safe from risk of abuse. Staff gave examples of signs and types of abuse and discussed the steps they would take to protect people, including how to report any concerns. The organisation had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary. A member of staff said, "There is a whistleblowing policy that we are all aware of. If I reported something that was a worry and nothing got done, I would inform the local authority and CQC, but I know the manager would listen and deal with it properly."

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "Everyone should be treated the same and be treated with dignity and respect. The same for the staff, we are all here to do a good job and personal differences and cultures don't change that." Staff were mindful of racism or sexism and respectful of people's differences. Staff had received training in equality and diversity.

There were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to keep people safe. People told us, "Always staff around if I need them, I think they are very well staffed." Another person said, 'I feel safe, staff help me if I need it. I don't call them unless I need them." We observed people received care in a timely manner and call bells were answered promptly. Staff told us they worked hard to ensure an immediate response and felt the number of staff on duty allowed them to do so. Staffing levels allowed for staff to support people when they needed it for example, taking people in to the garden

areas for a cigarette or just to enjoy the sunshine. We also saw that staff sat with people in the communal areas chatting and engaging them with different activities whilst other people started to join them.

There was additional staff in the home to respond to domestic, catering, entertainment, administration, rehabilitation and receptionist duties. The manager confirmed staffing arrangements were flexible and extra staffing was available to respond to any changes in people's needs. We found the staffing arrangements ensured people had their individual needs attended to.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. Interviews were undertaken and two staff completed these using an interview proforma. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse. Health professionals such as occupational therapists and physiotherapists were checked against the health and care professional council (HCPC) to confirm their fitness to practice.

Good

Is the service effective?

Our findings

At our last inspection in March 2017 we rated this key question as Good. At this inspection we found that the service had sustained this rating.

People were supported to maintain good health and received on-going healthcare support. People said that they could see the GP when they wanted as well as on the weekly GP visit, which was a great reassurance and were supported in attending hospital appointments. The GP was closely involved with the service and good relationships had been forged. Relatives confirmed health care support was sourced appropriately and they were kept informed of any health changes. Records and discussion with staff confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed regularly. This included dentists, opticians and chiropodists.

Each person had a multi-disciplinary care record which included information when dieticians, speech and language therapist (SaLT) and other healthcare professionals provided guidance and support. The provider had an occupational therapist working full time, a full time SaLT, part time consultant psychiatrist and full-time physiotherapist. This ensured a multi professional approach to providing the care delivery people needed. Input was also sourced from the falls prevention team and tissue viability nurse as required. People felt confident their healthcare needs were effectively managed and monitored. One person told us, "Amazing here, I am getting physio and I'm getting better everyday, I'm getting stronger."

Consent to care and treatment was always sought in line with legislation and guidance. The consultant psychiatrist employed by the service undertook a mental capacity assessment for people within the service and this was then reviewed monthly or before, if it should be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. The documentation to support decisions made on behalf of people was clear and stated the steps taken to reach a decision about a person's capacity.

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. All staff received training from the consultant psychiatrist in the principles of the Mental Capacity Act (MCA). Staff could give examples of how they would follow appropriate procedures in practice. During the inspection we heard staff ask people for their consent and agreement to care. For example, we heard the registered nurse say, "I have your tablets here, are you ready for them, do you need anything for pain. Staff asked people, "Shall I help you to the bathroom," and "Would you like another cup of tea." Staff were aware that some people's capacity could fluctuate daily and they ensured that this was recorded and that all staff knew of the changes. One staff member said, "We know to ask for consent before we give any care and support, we wait for a response, if we know they don't want help at that time, we go away, we never force or do anything without consent."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. During the inspection, we saw that the registered manager had sought appropriate advice in respect of these changes in legislation and how they may affect the service. The management team knew how to make an application for consideration to deprive a person of their liberty and had submitted applications where they were deemed necessary.

People received effective support because staff had the skills, knowledge and qualifications necessary to give people the right care. The provider continued to have oversight of what training had been completed across the service and of when training was due to be completed or renewed because there was an online training schedule to monitor this. Competency checks were in place to embed the learning from the on-line training. Staff told us that practical sessions on the floor took place by senior staff to ensure that they were doing things in the right way.

The service provided care and support to people who have complex and specific needs either due to Huntington's Chorea or an acquired brain injury. Service specific training, such as end of life care, acquired brain injury (ABI), Percutaneous endoscopic gastrostomy (PEG) care (a means of giving food when oral intake is not adequate or safe), catheterisation and catheter care and nutrition had been undertaken and updated to ensure best practice was followed by all staff. Staff told us that the training was "Really good" and enabled them to understand the people they cared for.

Staff supervision was up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. There was a supervision programme in place for 2018 which demonstrated that staff received regular supervision. Staff confirmed they received supervision every couple of months. One staff member said, "Really helpful, we can request training and if we need support for any reason we can get chance to talk it through."

People were supported to have enough to eat and drink to maintain their health and well-being. Menus were displayed in the communal areas and we were told that people were asked the day before what they wanted the next day. People's dietary needs and preferences were recorded and staff were aware of the importance of checking for any known allergies. One staff member said, "Not everyone can tell us so we always check for any allergies, such as nuts. Diabetic, vegan, soft or pureed and other special diets were available when required. No one living at the service required had any cultural preferences, but we were told that this would be arranged if needed. People told us the food was good, comments included, "Really good, no complaints," and "A lot of fish but we can have other meals, the suppers are really tasty." The menu offered choices of well-balanced nutritional food at mealtimes. There was one main meal choice but there was also a range of meals people could have such as jacket potatoes, egg, sausages, chips and salads. We saw that people had chosen a meal of their choice as we saw people enjoy different meals during the inspection.

We observed the mid-day meal service. The food was well presented and looked appetizing. Staff assisted people who required assistance in a way that was respectful and followed good practice. The person was in control of the meal. They ate at their own pace and select the foods to eat next. Staff positioned themselves in front or slightly to one side of the person they were helping, so they communicate more easily and remained in

Fruit was offered at meal and drink times. We were also told that snacks were available during the evening and night if someone felt hungry. One staff member said, "The kitchen is always open we can access simple

foods and drinks at any time."

The service provided care and support to people with swallowing difficulties, for example following a stroke and for those who lived with Huntington's Chorea. The soft diet was prepared and served in divided plates to maximise the appearance and segregate the tastes. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking. The service had a SaLT who joined the team in September 2016. Their input was valuable at MDT meetings and to train staff. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. At this time two people required a soft diet. We saw that this was followed in practice.

People's individual needs were met by the adaptation of the premises. The service was purpose built, with safe accessible gardens and plenty of communal areas. All bedrooms and communal areas of the service were on one level. All bedrooms have high specification profiling beds including a some for bariatric needs. Ceiling tracking hoists were available in most rooms. There were bathrooms with suitable wheelchair access and also a hydrotherapy bathroom. To enable people to achieve their rehabilitation goals, there was an occupational therapy kitchen and a fully-equipped physiotherapy gym.

Good

Is the service caring?

Our findings

At our last inspection in March 2017 we rated this key question as Good. At this inspection we found that the service had sustained this rating.

The culture within the service ensured people were treated with respect and dignity. The home had a relaxed atmosphere. People responded positively when staff approached them in a kind and respectful way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Really kind and patient" and, "Nice atmosphere, always upbeat." One person told us staff didn't try and rush them to get everything done. One staff member said, "The staff team is really focussed on caring, we have all learnt from the past experiences and really want to do our best, our residents deserve the best."

People were treated with kindness and respect and as individuals. It was clear from our observations that staff knew people well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Good morning (name) would you like me to help you," and, "Shall I take you to the lounge?"

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. When staff assisted people to move using an electrical hoist in communal areas they ensured their modesty was protected and they were moved respectfully. Staff told them what was happening and explained what they were doing. One person said, "I used to worry when they first used the machine but the staff are very good." Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private." This showed staff understood the importance of privacy and dignity when providing support and care.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "I know that I can express myself and staff will support me." Another person liked to look smart and told us staff ensured that their clothes were clean and pressed, we were also told, "I like to wear make-up especially if I am going out, I can't do it myself but staff help me."

We saw positive interactions between staff and people. There was a lot of laughter and staff used affectionate terms of address and gentle physical contact as they supported people. We also saw a care staff member sit with a person during their meal and encourage them with eating independently with gentle prompting, "Do you want help?" and, "Let me help you with that." This enabled the person to retain their dignity whilst accepting help. The SOFI told us that staff and people engaged positively using verbal and non-verbal communication. During the meal service staff sat alongside people and maintained eye contact whilst assisting people. The pace that staff assisted people was set by the person and not the staff member, which meant that the person was not rushed and enjoyed their meal.

Staff promoted people's independence and encouraged them to make choices. We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, its lunchtime soon." They knelt down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be. We give them space and respect their independence" and, "We let people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." Some people could confirm that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the dining area. Staff always ask me." Another person said, "Due to my health I spend a lot of time in bed, but staff do what they can to relieve my frustration, they pop in all the time and ask me if there is anything I need."

People's preferences were recorded in the care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different; they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and read, rather than participate in activities, were supported to do so.

People's rights to a family life was respected. Visitors were made welcome at any time and could have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. Newspapers and books were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. One relative told us, "We are always welcomed and feel at home, tea, coffee and cake is always offered." Another relative said, "I join in activities with my mother in law, the children love visiting her here, they feel comfortable and fun, always something going on."

People could express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

At our last inspection in March 2017 we rated this key question as Good. At this inspection we found that the service had sustained this rating.

People told us that the care they received was specific to them. One person said, "I have plans for my rehabilitation, exercises, and they monitor my improvement, it's been amazing here, I can see a future." Another person told us, "they are good, they know immediately when I'm not well."

Boyce Unit provided long-term care and support to people with complex needs relating to neurodegenerative disorders, such as Huntington's Chorea. Care plans for those people on Boyce Unit were devised to enable people to live a full and active life for as long as it was possible. Social needs, enablement of independence and prevention of isolation factored strongly within those care plans. For example, trips out to visit families, walks out into the local community and physiotherapy sessions to manage involuntary movements caused by their disease. Holman Unit was designed to be a specialised rehabilitation unit for post-acute acquired brain injury and neuro-behavioural rehabilitation. Holman Unit met individual specific behavioural needs alongside their physical needs. The occupational therapist worked alongside the physiotherapist to devise specific individualised care plans with achievable goals. These goals were set with each person on their arrival and monitored to ensure they were achievable. As changes occurred, goals were updated and new goals developed.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. Care plans to reflect one person's journey from an acquired brain Injury (ABI) showed how their individual goals to recovery were being met. Their mobility plan included advice and strategies from the physiotherapist and occupational therapist as to how to support them to stand and exercises to strengthen their limbs. Their goal was to walk again independently. We saw this person take steps whilst being supported by the staff team, which to them was a positive moment. Nutritional plans had been reviewed by registered nurses along with expert advice from the SaLT. Each person had an individual care plan tailored to meet their specific needs and they had been regularly reviewed to reflect changing needs. One person was on a diet to lose weight to improve their overall health. There was continued monitoring of the person's weight loss and daily input from staff to manage this in a way that promoted their health and well-being. The management team acknowledged that improvements were on-going and now all care plans had been transferred to a computer system, further amendments to the system were being developed to ensure a 'live' document that reflected people's daily lives. We looked at four care plans and saw all were up to date and reflective of individual needs.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. There was no one at present who was receiving end of

life care. However they were because of their illness approaching the final stages of their illness. The documentation reflected that care had been adjusted for approaching this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring that food and fluids should be offered regularly in small amounts.

The staff team had a good understanding of the Accessible Information Standard and discussed ways that they provided information to people they supported. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Services must identify, record, flag, share and meet people's information and communication needs. Hospital Passports had been devised to share information with other to record how people communicated, triggers that may cause behaviours that challenge, medication and allergies and how staff supported people with their personal needs. Staff told us of different methods they used to communicate with the people they support. Flash cards and pictorial methods were used for those who were unable to verbally express their choices. For those people with problems with their eyesight, staff looked at lighting, documents were printed in a large format or on a different colour paper. We were also told they could use voice tapes if required.

Technology was used to promote independence and well-being within the service. For example, there was a spacious occupational therapy kitchen with units that can change height to accommodate wheelchairs. People used this facility to make tea, coffee and simple meals to prepare for independent living. There was also a fully-equipped physiotherapy gym with a hydrotherapy bath to benefit people's strength and muscle tone. Technology was also used to enable people to remain in contact with families and friends with access to Wi-Fi and mobile phones and iPad.

Activities were planned and tailored to meet peoples' preferences and interests as much as possible. We were told that the format of activities may change on the day depending on who chose to attend and how many. Each person had an individual weekly activity plan which staff supported people to follow. This included one to one meetings, physiotherapy and occupational therapy sessions. There was also a weekly general programme that included film showings, quiz sessions and trips out in the garden and community. During our inspection we saw several activities taking place and enjoyed by people. These included various one to one sessions, individual exercise and physiotherapy sessions. Praise and encouragement was done in a respectful manner and people were relaxed and enjoying these activities. Staff were committed to improving people's lives by ensuring that they were not isolated either in their room or in the communal areas by either reading to them or putting music on.

Regular staff and resident/family meetings were held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the chef. The minutes of meetings were shared with people and families and displayed in the home.

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log is kept and monitored by the registered manager. There was evidence that complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I have been asked to complete forms about food - I give feedback all the time."

Good

Is the service well-led?

Our findings

At the last inspection this key question was rated requires improvement. This was because people's documents were not always accurate and up to date. At this inspection we found further improvements had been made and the rating had improved to Good.

The registered manager had been in post for 2 years and was supported by a deputy manager and a multi-agency team. This included a consultant psychiatrist, Physiotherapist, Occupational therapist and SaLT. There was also an area manager and provider that completed the management team.

Effective management and leadership was demonstrated in the home. The registered manager was knowledgeable, keen and passionate about the service and the people who lived there. There had been a turnover of staff in the past two years but this had provided a fresh and open culture which had benefited the service. The management team were open and transparent about the challenges they had faced, but were very proud of what the staff team had achieved in the past year. They were committed to embrace the changes and continue to grow and develop the service.

Without exception every person, visitors and visiting health professionals talked of the warm, caring and knowledgeable team of staff. One person said, "Brilliant staff, very patient and understanding, it's frustrating having people have to assist you in everything but they do it with such care." A visitor said, "Excellent, I am kept informed, the staff explain everything."

There was a registered manager in post. The management structure, staff retention and recruitment at The Priory Hospital Heathfield had been consistent since the registered manager took up the role and this had impacted positively on the action plan delivery.

Effective management and leadership was demonstrated in the home. The registered manager took an active role with the running of the home and had good knowledge of the staff and the people who lived there. They told us that the philosophy and culture of the service was to make The Priory Hospital Heathfield 'People's home' as well as promoting independence. They also told us, "It's important that we make it comfortable, homely and safe but still deliver a rehabilitation service with clear goals to get people home."

There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly by people and staff. The registered manager said their door was always open if staff wanted to have a chat with them. One member of staff said; "It's a different place now, open and transparent, easy to talk to." Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Staff told us that the philosophy and culture of the service was to make high quality care and promote independence. Staff spoke of the home's vision and values which governed the ethos of the home. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good

quality care and person specific care. The registered manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was apparent staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

Systems for communication for management purposes were established and included a daily meeting with the senior staff. These were used to update senior staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The manager is open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person and handed over medicine room keys. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "I feel that we are listened to, I enjoy working here."

Quality monitoring systems had been developed and sustained since the last inspection. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so quality of care was not compromised. Areas for improvement were on-going such as care documentation. The registered manager said recording was an area that they wanted to continuously improve. All care plans were up to date and reflective of people's needs. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned, such as laundry service and menu choices.

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. On discussion with the registered manager, future actions of persistent falls and incidents may include looking at a more suitable room location for certain people. This would only happen if it is in the best interest of the person. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff all work well with us, communication has improved," and "We work as a team."

The registered manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at The Priory Hospital Heathfield to share their thoughts, concerns and ideas with them to enhance their service. Friends and relative's meetings had taken place and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I think they really want our input."

Staff meetings had been held regularly over the past year and staff felt informed about changes and plans for the home. One staff member said, "It's really great to be involved."

Comments from external professionals were positive. we were told, "Very knowledgeable, they know the people they support very well." The local GP worked alongside the service consultants and did a multi-agency ward round every week. This showed that staff worked with in partnership with external agencies to support joined up care.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.