East Sussex County Council

Firwood House

Inspection report

Firwood House
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22 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Firwood House provides intermediate care for up to 20 older people. It provides nursing and personal care for people who require a period of rehabilitation to recover from an injury or illness. For example following a fall, illness such as a stroke or surgery such as joint replacement. There were 20 people staying at the service at the time of the inspection. People who meet the admission criteria usually stay between two to six weeks. The aim of the service is to maximise people's ability to live independent lives, improve their health and prevent admission to hospital. Firwood House is run by East Sussex County Council in conjunction with East Sussex Healthcare NHS Trust.

There is a registered manager at the service. 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.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 20, 21 and 22 June 2016.

People were supported by staff who knew them well and had a good understanding of their individual needs, choices and preferences. Staff were committed to supporting people to achieve their goals and return to independent living. They treated them with kindness and respect whilst encouraging them to do things for themselves. We found people's records did not always accurately reflect the support people required. These shortfalls had not been identified by the audit system. We have made a recommendation about this.

There were systems in place to ensure the management and storage of medicines was safe. However, there were no PRN protocols in place to ensure people who needed 'as required' medicines received them consistently. We have made a recommendation about this.

Risks assessments were in place, staff had a good understanding of the risks associated with people they were supporting. However, risks associated with pressure area care were not always well managed.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

There were enough support staff, nurses and therapists on duty who had been appropriately recruited to safely meet people's needs. Staff sought and obtained people's consent before they supported them. They understood the requirements of the Mental Capacity Act (MCA) 2005 when helping people to make decisions. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered.

People were provided meals that were in sufficient quantity and met their needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences and support they required at mealtimes.

Staff were knowledgeable and competent to meet people's needs. They received ongoing training and support to help them meet the needs of people who used the service. Staff told us they received regular supervision and felt supported by their line manager and the registered manager.

There was an open positive culture at the service, where management and staff were committed to treating everyone as an individual and providing a good level of support to people who used 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?

Requires Improvement

Firwood House was not consistently safe.

The management and storage of medicines was safe, and people received their medicines as prescribed. However, improvements were required to ensure PRN protocols were in place.

There were enough support staff, nurses and therapists on duty who had been appropriately recruited to safely meet people's needs.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

Risks assessments were in place however risks associated with pressure area care were not always well managed.

Firwood House was clean and tidy throughout and well maintained.

Is the service effective?

Good

Firwood House was effective.

People were supported to maintain a healthy diet and were involved with the planning of menus. However, there were nutritional assessments to identify people who may be at risk of malnutrition.

Staff were suitably trained and supported to deliver care effectively.

Staff ensured people had access to external healthcare professionals when they needed it.

The manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Firwood House was caring.

Staff knew people as individuals. This enabled them to support them to make decisions about their individual goals to enable them to regain their independence.

People were treated with kindness, compassion and understanding.

Is the service responsive?

Good

Firwood House was responsive.

People received care and support that was responsive to their needs because staff knew them well.

People were involved in planning their own goals and identifying what support they needed to return to independent living.

Feedback was sought from people about the overall quality of the service. People's views were listened to and acted upon.

Is the service well-led?

Requires Improvement

Firwood House was not consistently well-led.

We found areas that needed improvement during the inspection however these had not been identified within the service's quality monitoring processes.

There was an open positive culture at the service, where management and staff were committed to treating everyone as an individual and providing a good level of support to people who used the service.

Firwood House

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 was an unannounced inspection on 20, 21 and 22 June 2016. It was undertaken by three inspectors one of who had specialist knowledge of working with rehabilitation services.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records staff files including staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at seven support plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people who used the service. This is when we looked at their care documentation in depth and obtained their views on the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with seven people, four visiting relatives, and fourteen staff members including the registered manager and a visiting healthcare professional. We also spoke with senior managers from the organisation who visited the service throughout the inspection.

We met with people, we observed support which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals.

We previously inspected Firwood House in January 2014 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Firwood House. They said they received their medicines when they needed them and could contact staff any time they needed to. We observed people approached staff freely and appeared comfortable in their company.

Staff told us there was enough support and nursing staff working at the service. There were six support staff and two nurses working each day. Staff told us if there were absences they were covered by colleagues or agency staff. Agency staff worked regularly at the service, they knew the service well and had the appropriate knowledge and skills to support people. The amount of nursing staff working had recently been increased to two per shift during the day and nurses told us this had been required to ensure they could meet people's needs safely. We observed people were attended to in a timely way. Although staff were busy most of the time they were able to spend time talking to people and care delivered was not rushed. Where extra support staff were required, for example if somebody required one to one support we saw this was provided. The duty support worker completed a staffing levels risk assessment each day which highlighted to the registered manager if there were not enough staff to support people safely.

A physiotherapist, a physiotherapy assistant, an occupational therapist and an occupational therapy assistant worked each Monday to Friday. They were employed by the local NHS trust. The registered manager told us they were reliant on the NHS trust to provide replacement therapy staff in the case of absence. The registered manager told us therapy cover was consistently appropriate to meet the needs of people using the service.

People's medicines were provided by the NHS trust and the medicine system was overseen and supported by a pharmacist. When people transferred to the service the nurses obtained a copy of the medicines they were taking prior to their hospital admission from their GP. They then transcribed the medicine information from the person's hospital Medicine Administration Record (MAR) chart and compared it to the medicines people were taking prior to admission to hospital. This was further checked against the medicines people had actually been discharged with. Through this process the nurse was able to identify if people had been prescribed the correct medicines. The nurse explained that sometimes people had been prescribed medicines that they took for example every three months. The hospital staff may not be aware of this and this may result in important treatment being missed. To enable nurses to transcribe the medicine information they undertook specific training to ensure they were competent to do so. Once the nurse had transcribed the medicines it was checked and signed as correct by a second nurse. This was further checked by the pharmacist at their weekly visit. The process was robust and helped ensure people had been prescribed all the medicines they required.

Medicines were stored, administered and disposed of safely. People's medicines were stored in locked cupboards in their bedrooms and given to people individually. We observed medicines being given at lunchtime; these were given safely and correctly as prescribed. Some people were able to take their own medicines and risk assessments were in place to demonstrate they were safe to do so. Where required medicines had been provided in blister packs to enable people to retain their independence.

Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. The nurses knew people well and were able to tell us why people may require their PRN medicines. Prior to administering PRN medicines staff asked people if they required them to ensure medicines were not given unnecessarily. However, there were no individual protocols to show why people had been prescribed these medicines or when they may be required. There was no information about when it may be given, any contra-indications with existing prescribed drugs or what to do if the medicine was not effective. The nurses told us they were professionally accountable for decisions they made. They said these would be made following discussions with people and based on their clinical and individual knowledge of people. There was a current reliance on agency nurses and whilst we were told all staff were fully updated at handover there was a risk people could receive medicines unnecessarily or be left distressed. This was addressed during the inspection.

We recommend the provider reviews PRN protocols to ensure all staff have access to detailed information when required.

People were protected against the risk of poor care and support because staff knew them well and had a good understanding of the risks associated with supporting them. There were a range of risk assessments in place. These related to people's mobility, skin integrity and falls. There was guidance on the handover document to inform staff of the support people required. For example the handover document informed staff about people who required pressure area care.

During the inspection one person had been identified at risk of developing pressure sores. A pressure ulcer prevention plan and a pressure relieving air mattress had been put in place. We found the mattress had not been set correctly for the person's weight and there was no system in place to monitor the settings. This meant the equipment would not be as effective at protecting this person's skin integrity. We raised this issue with the registered manager who introduced a monitoring system immediately. This is an area that needs to be improved to ensure the process is fully embedded into practice.

People were protected, as far as possible, by a safe recruitment practice. Records seen of staff employed directly by the provider included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring check (DBS) these checks identify if prospective staff had a criminal record or were barred from working with people. The nurses and therapists were recruited and employed by the local hospital trust. An administrator ensured relevant information which included a copy of their DBS number and checks to ensure nurses were appropriately registered with the Nursing and Midwifery Council (NMC) were in place. The registered manager was able to access this information as required.

Staff had a clear understanding of abuse, how to identify it and protect people from the risk of abuse or harm. Staff told us all concerns would be reported to their line manager in the first instance. They told us if this was not appropriate they were able to report to any other senior support worker, a nurse or registered manager. Staff were also aware of their individual responsibilities in ensuring concerns were reported appropriately. All those we spoke with referred to the safeguarding flow chart on display which they could refer to. One staff member said, "I hope I wouldn't have to but if I was worried I would follow the flow chart and refer to the safeguarding team myself." Records showed staff received regular safeguarding training updates. They also completed competency assessments to ensure they had retained their understanding following training. Staff who were employed by the NHS trust were required to follow their own reporting policies in addition to the provider's safeguarding policy.

There were systems in place to deal with an emergency which meant people would be protected. There was

guidance for staff on what action to take and there were personal evacuation and emergency plans in place. The home was staffed 24 hours a day with an on-call system for management support and guidance. Regular health and safety checks were in place and these included water temperature and fire safety checks. We saw staff had received fire safety training including fire drills. There was regular servicing for gas, electrical installations, lifts and hoists. Day to day maintenance was recorded and signed when completed. The manager was pro-active in ensuring maintenance issues were addressed in a timely way.

Good

Is the service effective?

Our findings

People told us they were supported by staff who had a good understanding of the support they needed. They told us they enjoyed the food and had a good choice of what they could eat and drink.

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 and hospitals 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. Prior to using the service people had been assessed as having capacity. Where this had changed following admission we saw appropriate measures had been taken. Best interest meetings were held and DoLS authorisations were in place. Staff told us how they supported people to ensure restrictions were kept to a minimum. One staff member said, "Even when people are under constant supervision we still make sure they make their own choices and decisions whenever they can."

When people started using the service they signed consent forms. These showed people had agreed to participate in their own care programme and share information with other professionals. Throughout the inspection we observed staff asking people's consent before offering any care or support. Staff demonstrated a good understanding of MCA and DoLS. They received regular training and had undertaken competency assessments to demonstrate they had understood the training they received. They were able to tell us about the five principles of the MCA. One staff member said, "If people don't have capacity then we have a best interest meeting to make decisions." Another staff member told us, "MCA and DoLS protect people who can't make their own decisions."

There was a training and supervision programme in place. When support staff started work at the service they had an induction period where they shadowed other staff to get to know the day to day running of the service. They also completed the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There were systems in place to ensure staff received the appropriate training and support to meet people's needs. Staff undertook a range of essential training such as infection control, moving and handling, health and safety and first aid. Competency assessments and observations of staff in practice were undertaken by senior support workers to identify any areas where further training was required.

Support staff received training which was specific to the needs of people who used the service. This included the reablement assistant programme (REAP). REAP training teaches staff how to support people back to independence. Staff told us the training was helpful, they said it taught them how to stand back and allow people to do things for themselves rather than doing things for people. Training was audited regularly to

ensure it was delivered and received in line with the provider's policy.

Staff received regular supervision from the registered manager, deputy manager or senior support worker. Supervision included an opportunity to discuss training and development opportunities and review practice. Staff told us they felt supported by the registered manager and senior staff at the service. They told us even though they had a line manager they were happy to discuss concerns with any senior staff.

The nurses and therapists received the majority of their training from the local NHS trust. All staff spoken with were able to confirm that they have access to mandatory training on line and were able to access bespoke training as required if able to evidence need and value. Therapy staff confirmed that they received regular professional supervision along with annual appraisal. This was overseen by the administrator and records confirmed this had taken place. The nurses told us they received supervision from the matron who worked at the service, or in their absence another senior nurse. Nurses and therapy staff confirmed they had the support of the registered manager and their professional leads to pursue external training and courses.

People received meals that were nutritious and healthy and met their individual choices. The cook and staff had a good understanding of people's dietary needs in relation to specialised diets for example diabetic and individual preferences and allergies. There were regular meetings where people were asked what they would like to be incorporated into the menu. The cook told us they were given a handover sheet each day which updated them about people's dietary requirements. People had a choice of meals, which were freshly cooked each day and included a cooked breakfast at weekends. There was a large dining room on the ground floor of the building. The cook told us, "People are asked every day what they would like to eat. There are usually two main meal options. If they don't like anything there are alternatives. If there are any problems regarding food I will talk to people and work something out with them."

Mealtimes were sociable occasions. At lunchtime people were asked where they would like to sit and were assisted appropriately. Once they were seated people were asked whether they were close enough to the table. We saw that friendship groups had formed and some people chose to sit together. Tables were nicely presented and included a copy of the day's menu. Food was presented in a way people liked, for example people were asked if they would like gravy, or where they would like their vegetables. Staff were attentive throughout the mealtime, they ensured people received the support they required, for example cutting up their meals. One member of staff went around each table to check that everything was alright. One person had poor vision. We observed staff describing to the person where their food was on their plate. They used a clock face to describe the position and ensured the person knew where their food was before they left. Following the meal people were asked if they had eaten enough or if they would like more. One person told us, "The food is good here, and you get seconds." Although people were encouraged to eat in the dining room some people chose to eat in their bedrooms. We saw their meals were nicely presented and staff provided the appropriate level of support. A choice of soft drinks was offered throughout the meal, and hot and cold drinks were offered regularly throughout the day.

There were nutritional assessments in place to check if people were at risk of malnutrition or dehydration. One person had been identified at risk of malnutrition. The nutritional assessment indicated the person should be referred to a dietician for advice. However, staff had noted this person was gradually gaining weight whilst at the service so a referral had not been made. This person's dietary intake was monitored to ensure they continued to eat a satisfactory amount. Staff told us if the person did lose weight then an appropriate referral would be made. Staff were observant as to what people ate and drank throughout the day. If they identified any concerns then the food and drink was recorded for staff to monitor.

The accommodation was on the first floor of the building. There was a lift which provided level access to the

ground floor where people could access the dining room, an activities room and a lounge with a television. On the first floor there was a smaller lounge with tea and coffee making facilities. People were able to use this as a quiet lounge or to meet their friends and families. There was a range of specialist equipment which was available for people when required.

People's health needs were supported by a local GP surgery. A GP visited the service at least four times a week to review people's ongoing health needs and for example discuss medicines they may be taking. If people's health needs changed then the GP would be called appropriately. We saw one person had become unwell and appropriate emergency services had been contacted to ensure the person was reviewed appropriately. A visiting healthcare professional told us they were contacted and staff had a good understanding of people's health needs.

Following their rehabilitation some people required ongoing care and support to enable them to live at home safely and as independently as possible. Planning for discharge was an important part of the service. People were reviewed by the social worker to ensure the appropriate support was in place when they went home. Their progress and future needs were discussed at weekly multi-disciplinary team meetings which involved all professionals. In addition to people's physical needs their social support needs were discussed for example some people looked after relatives who they lived with. This was taken into account when planning their discharge. The occupational therapist completed a home visit with people prior to discharge to ensure they had all the equipment they required to support their independence. There was a discharge process checklist in place to guide staff through the process and ensure all support was in place.

Good

Is the service caring?

Our findings

People told us they felt well supported during their time at Firwood House. One person told us, "Staff are very good." Another person said, "Staff are lovely, I couldn't wish for anything better."

Although people did not stay at the service for long staff still knew them really well. They had a good understanding of their individual needs, choices and preferences. They were aware of people's physical and psychological support needs. They provided comfort to people through verbal reassurance and displayed an empathy with people. One person appeared anxious and unwell and did not wish to leave their room. Staff recognised this and spent time with them, staff shared their concerns with senior staff to ensure the person was supported appropriately. People were familiar with staff and happy to approach them if they had concerns or worries. There was good humour between people and staff made time to talk to people whilst going about their day to day work.

We observed one staff member spending time getting to know a person who had recently arrived at the service. The staff member attended to the person's individual needs such as ensuring they had a cup of tea, and introduced the person to the environment. Throughout the inspection we observed staff supporting people to get to know each other and as a result a number of friendships had developed.

People were treated with kindness and understanding. Interactions and conversations between staff and people were positive and encouraging. The purpose of the service was to support people to return to independent living. We observed staff prompting and encouraging people to enable them to do this, staff gave people the time they needed to work at their own pace.

People understood their individual rehabilitation goals, they told us what they needed to achieve. One person told us how they had started walking with a mobility frame and had now progressed to two sticks. They were aware they needed to be walking with one stick before they could go home. They told us staff were kind and supported them as they needed it. One person said, "It's up to me, if I need help I'll ask." Staff told us they were aware of people's needs and would intervene when they needed to but were aware of the importance of encouraging independence. One staff member said, "If I do things for people, I'm not really 'helping' them."

People were involved in decisions about their day to day care. Before starting to use the service people were aware the purpose of their stay was for rehabilitation. This meant there was some routine and structure built into their day to enable them to achieve their goals and independence. However, people were still able to choose what they done during the day and were able to decide if they did not want to participate in their care. One person told us, "It's up to me what I do, I can get up when I like and go to bed when I like." Another person said, "Its lovely, you're free here." One staff member told us, "We give people choices and we try to persuade them to join in however it is up to each person." Another staff member said, "People are never forced to participate or do something they're not comfortable with." Staff told us if people declined to be involved in their support they would try and find out why. They explained often people were anxious about joining in with other people. One staff member added, "People get a lot of support from each other that's

why we encourage them to socialise."

People's privacy and dignity was respected. They took an interest in people and referred to them by their preferred name. Bedroom doors and curtains were kept closed when people received support from staff and staff knocked on doors and waited to be invited in on all occasions. Bedrooms were functional but we saw people had a number of their own personal belongings that reflected their hobbies and interests. People were supported to dress in their personal style and staff respected the choices they made.

People were encouraged to maintain contact with their friends and family and visitors were welcomed at the service. One visitor told us, "It's lovely here, staff are nice and our relative is well looked after."

Good

Is the service responsive?

Our findings

People were involved in an assessment and planning of individual goals when they started using the service. One person said, "I know what my goals are and what I need to do to go home." Another person told us, "I couldn't do the stairs but I can now with the staff." People told us they had no complaints or concerns but if they did they would raise these with staff or the registered manager.

Before people started using the service they had been assessed as needing a period of rehabilitation by staff at the NHS trust. Staff who made the referrals were aware of the service that was provided and the referral criteria. However, staff had identified this criteria was not always followed and there was not always enough information about the person provided. The registered manager and staff were identifying different ways to address this to ensure people were appropriately referred and staff had accurate information. This included senior care staff or therapist meeting with people whilst they were still in hospital. When people had arrived at the service and later identified as unsuitable for rehabilitation and for example had to be readmitted to hospital an incident form was completed to identify any themes and trends and prevent a reoccurrence.

People were involved in developing their own support plans and identifying what they needed to achieve to become as independent as possible. When people were admitted to the service an assessment took place which included identifying whether the person was, for example, at risk of falls or pressure area damage. These assessments were completed within three hours of admission to ensure staff were aware of people's needs. These were checked and signed when completed. There was a checklist for discussion with people on admission. This included an introduction to the layout of the service, the fire procedure, any dietary needs or preferences and consent forms.

People were asked about the circumstances that had led them to need rehabilitation. One person had stated they had fallen a lot at home and needed to become more stable on their feet. People were also asked what needs to be achieved before they could go home. One person stated they needed to walk up two steps as this is what they had at home. Another person had stated they needed to be able to empty their own catheter bag to ensure they were independent. People's bedrooms were positioned as they would be at home. To ensure for example if people got out of the right side of the bed at home they would do the same at Firwood House.

Following assessment by the physiotherapist and occupational therapist people had individual rehabilitation goals set. These were recorded in the support plan and also on white boards in people's bedrooms. People talked to us about their goals, and were aware of what they needed to achieve, this included exercises they needed to do. One person said, "Its good when you see them being ticked off on the board." People's goals and progress were regularly reviewed and documented within the daily notes. Other important information related to people's support was recorded on a separate white board for example what type of mobility aid they required to walk with. Some people were at risk of falls, they had posters displayed to remind them to call staff before they started to walk. One person said, "I start to get up then think, I must call someone, I don't want to fall again."

Staff were updated about people's support needs at daily handover meetings where staff received a handover sheet documenting people's current needs. Support staff and nurses met daily to discuss the support people had received that morning and identify any areas of change or concern. Although people stayed at the service a relatively short time staff knew them well and had a good understanding of their individual needs. People's progress was discussed at weekly MDT meetings. If there were concerns staff would discuss how they could support people appropriately. For example one person was quite distressed and unable to participate in their rehabilitation and wished to return home. Staff identified this person would benefit more from being at home than remaining in the service. Referrals had been made to appropriate professionals for support, this included community physiotherapists to continue the rehabilitation programme. Another person was reluctant to eat and drink, various ways of increasing the person's intake was discussed this included a referral to the GP for possible further investigations.

We observed staff supporting people in ways that helped them achieve their goals and regain their independence. At lunchtime staff assisted people to the dining room. Some people used the stairs with the support of staff others used the lift. We saw people walking with their appropriate mobility aids. Other people were using mobility aids and staff followed with a wheelchair so people could sit down if they became tired. Staff told us, "It's a long way to the dining room but its important people are able to walk at their own pace but stop if they are tired."

During the morning people attended an activity session (gym) which included chair based activities to support people's rehabilitation. Staff worked hard to ensure people were supported to attend and felt included in the activity. Once a week there was a 'well-being' group. The aim of the group was to discuss what promotes and prevents well-being. Staff told us people discussed whatever they chose but this usually included the reasons for them being at the service, the progress they had made and any concerns they had about their progress. Staff told us it was a supportive environment where people were able to learn from each other and promote their own well-being.

Staff told us during the afternoon people were able to participate in less physical activities such as board games however we did not witness any of this during our inspection. We overheard one person remarking at lunchtime they found the afternoons boring. The registered manager and staff told us they were aware there needed to be more for people to do during the afternoons and they were working to introduce more activities. We asked other people if they had enough to do during the day and people told us they did. One person told us, "I have plenty to do, I'm never bored." Another person said, "By the time I've got up, attended 'gym', had lunch and done all my exercises I don't have any energy for anything else."

People were listened to and regularly asked for their feedback. People's feedback was on display in the main entrance hall to the building. People were asked to fill in a 'leaf' which was then attached to a painted vine on the stairwell. Staff asked informally throughout the day when supporting people. There were monthly meetings where people were asked their opinion about their stay, meal choices were discussed and any concerns identified. People were given a copy of the complaints policy which explained how to make a complaint, and how the service would respond. The policy was included in the information pack given to people on the commencement of a service. The policy set out timescales that the organisation would respond in, as well as contact details for outside agencies that people could contact if they were unhappy with the response. The registered manager and staff took all complaints and concerns seriously. When concerns were identified staff informed the registered manager who then discussed the matter with the person and asked if they would like to make a formal complaint. During the inspection a number of people's discharge from the service had been delayed due to the lack of community support available. The social worker discussed this with people and explained the reasons for the delay. People were then asked if they would like to make a formal complaint and would be supported to do so if they wished. Where formal

complaints had been received they were responded to appropriately. The service had received a number of compliments; these were recorded and responded to by the registered manager with a note of thanks.

Requires Improvement

Is the service well-led?

Our findings

People told us they felt listened to and were happy to discuss any concerns with the registered manager and staff. Staff told us they were well supported and could talk to the registered manager or senior staff at any time.

There was an audit system in place to monitor the quality and safety of the service and make continuous improvements. However, the system did not identify some of the shortfalls we found in relation to people's records. For example we found some people had catheters in place, there was a catheter passport which contained information for the person. It also showed when the catheter had been changed and why this was needed. However, there was no guidance for nurses to follow to show if the catheter could be changed by a nurse or what action should be taken if the catheter should block. Some people were diabetics. We saw their blood sugars had been recorded however there was no information about what the normal range of blood sugar was for each person. There was no information or goal for how people were being supported and enabled to maintain their own diabetes. Therapists had identified goals for people to achieve, people had identified their own goals within the support plans but the therapy goals were not linked to support plans. Within the daily notes there were updates of people's goals and progress however it was difficult to identify people's progress and current goals due to the amount of information. Staff were reliant on the daily handover document to update them about people's needs but not all the information from the handover had been used to update the support plans. This did not impact on people because staff knew them well however there was a risk people may receive care that was not consistent. We identified this with the registered manager as an area that needs to be improved.

We recommend the provider ensures care records that reflect all people's needs are put in place.

There was ongoing improvement and development at the service through analysis of incidents and accidents. People did not stay at the service for long periods of time and it was more difficult to identify themes and trends. Therefore following a fall the registered manager identified any changes that could be made to prevent a reoccurrence. For example it had been identified one bedroom was not suitable for people who used a certain mobility aid. Another person had fallen after they had been admitted to the service late at night and appropriate paperwork had not been completed. As a result no admissions were now accepted after 4.30pm and only one admission would take place if an agency nurse was working at night. The registered manager had a large plan of the service on the wall which was updated each time an incident or accident occurred to see if a pattern developed over time for example in a particular bedroom or area of the service.

There was a real commitment from the registered manager and senior managers within the organisation to ensure a good working relationship which resulted in positive outcomes for people between the provider and the NHS trust. Some of the oversight of the way the service was run was based on trust and goodwill between the two employing organisations. For example nurses and therapists were interviewed, recruited and employed by the NHS trust who were also responsible for their training and supervision. The registered manager and provider were able to access these records but were not involved in identifying areas where

nurses and therapists may require support or further training. The registered manager told us she worked closely with the matron who was responsible for the clinical needs of nurses.

The provider and registered manager were aware possible issues could arise due to the joint working environment between the provider and the NHS trust for example the use of separate polices. We identified the nurses were following the medicine policy from the NHS trust which did not include all the guidance required. We discussed this with the registered manager and senior managers from the provider who told us policies from the provider were now being followed. They told us issues such as this did arise from time to time but were addressed through regular joint meetings and a desire by everybody to succeed. They told us development of the service was part of the 'East Sussex Better Together' program to develop a coordinated local health and social care system to ensure people receive support from health and social care services that enables them to live as independently as possible and achieve the best outcomes.

The registered manager had developed an open and positive culture. She worked at the service most days and was approachable and available to staff. She was passionate about ensuring people were treated as individuals, listening to people and understanding everyone's pathway was individual to them. These values were shared by staff who demonstrated to us their knowledge of the importance of person-centred care. The registered manager had a good understanding of the service where areas for development were required and was working with staff to develop these, for example the activity program for people. Staff told us they were well supported by their line manager, senior staff and the registered manager. They told us they could speak with her at any time and know their concerns would be addressed appropriately and confidentially. Nurses and therapists told us they could talk to her and felt she would address any concerns. We observed a close working relationship between the registered manager and the nurses.

There was a range of regular meetings held at the service these included development meetings, staff meetings for all staff and different staff groups. Staff told us they were able to participate in the meetings and feel they were listened to. Minutes were available for staff who did not attend. There were a range of lead roles for example one senior support worker was responsible for maintenance checks and another for developing the activities programme. Staff we spoke with were aware of their roles and responsibilities and who to report to if they had any concerns. Staff told us the service provided was good. One staff member said, "We do rehabilitate people, this service is second to none."