Select Health Care Limited

Jubilee Court Neuro-Rehabilitation

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 13, 14 and 15 June 2017 and was unannounced. Jubilee Court Neuro-rehabilitation is a purpose built rehabilitation centre. It provides accommodation with personal care and nursing for up to 30 adults who have acquired brain injury. At the time of our inspection 23 people were using the service.

The service has a manager in post who has submitted an application to the Care Quality Commission to become the registered manager. The previous registered manager left in December 2016.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At a comprehensive inspection in May 2016 we found the provider was not meeting the law in respect of the governance of the service and provision of systems which effectively assessed, managed and monitored risks to people living at the service. We also found at the May 2016 inspection the provider needed to make improvements to ensure staff were familiar with the Mental Capacity Act. We carried out a focused inspection in December 2016 and found the provider had made improvements which meant they were meeting the law. At this inspection in June 2017 we found improvements had not been maintained and the provider was again not meeting the law in respect of ensuring there were systems of good governance.

Most people received their medicines as prescribed. Some medicine shortfalls had not been identified and addressed in a timely manner. The lack of a clinical lead to oversee the clinical support provided to people impacted on the care and treatment people received. Assessments of risks had not always been completed or followed in relation to some people's medical and healthcare needs. People's needs were met by sufficient members of staff but we did see instances when the deployment of staff impacted on the way these needs were being met. Staff had received training and knew how to recognise and respond to abuse. Staff were recruited in a safe way.

Some improvements had been made and staff were familiar with the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). However staff were not fully aware of how to support people in the least restrictive way, and the provider was not always able to demonstrate how they were complying with the requirements of people's Deprivation of Liberty authorisations. Staff generally sought people's consent before providing their support. Staff received training for their role but not all staff had completed training which was specific to the needs of the people they supported.

People were supported by staff who they described as kind, friendly and caring and who protected their privacy and dignity. People were treated as individuals and their personal preferences were respected. People knew how to raise concerns and a procedure was in place, although we found that not all

complaints had been recorded to enable us to see the action that had been taken.

People were supported by a therapist team that focused on their rehabilitation goals and aspirations. The provider employed activity coordinators who facilitated a range of activities, and encouraged people to participate in activities that they enjoyed. People were supported to maintain relationships with people who were important to them and visitors were welcomed in the home

Although the provider had quality assurance systems and processes in place to support them to monitor the quality and safety of the service, some of these systems and processes had not identified the shortfalls that we found during our inspection and further improvements were required. We found that although the provider addressed the concerns and shortfalls as they were identified a more proactive approach was not being followed to ensure improvements were sustained and lessons were learnt.

We found the provider was in breach of one of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risks associated with their care needs because risk assessments and management plans were not always sufficiently detailed or followed.

Most people received their medicines as prescribed.

People said they felt safe and staff understood their role in recognising and reporting abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff knew which people were being deprived of their liberty but they did not always have the knowledge about the conditions attached to some of these authorisations to ensure they were being met.

Staff received training for their role but not all staff had received training which was specific to the needs of the people they supported.

People were supported to eat and drink enough to maintain their health.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not always demonstrate a caring approach to ensure people received the care and support that meet their needs.

People described staff as kind and caring and confirmed their privacy and dignity was met.

Staff knew people well and supported them in accordance with their preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care that was responsive to their needs.

People were not always involved in the on-going reviews of their care to enable them to contribute to this process.

People were supported to engage in meaningful activities of their choice and people received rehabilitation support and had plans in place to work towards their goals.

People knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led

The provider had systems in place to assess and monitor the quality and safety of the service. However, these were not always effective in identifying shortfalls in the service. There was a lack of clinical oversight in the service to ensure people's clinical needs were met.

People and representatives felt the management of the service were approachable.

Staff felt supported and understood their roles and responsibilities.

Jubilee Court Neuro-Rehabilitation

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13, 14 and 15 June 2017 and was unannounced. The inspection was undertaken by two inspectors, and a nurse specialist advisor. The specialist nurse advisor provided specialist nursing advice and input into our inspection process.

We asked the provider to complete 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. The provider returned this form before our inspection so we took this information into account when we planned our inspection. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We also contacted the local authority who monitor and commission services, for information they held about the service. At the time of our inspection due to concerns, the provider had been suspended from accepting any new admissions to the home by the local authority. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke with seven people, eight representatives/ relatives, three nurses, eight care staff, a physiotherapist, two occupational therapists, the head cook, a domestic, the maintenance person, a visiting healthcare professional, the acting manager and area manager. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection (SOFI) and general observations of the care and support staff offered people. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of 13 people to see how their care was planned. We reviewed medicine administration systems and associated records for two people. We looked at training records for staff and at three staff files to review the recruitment processes. We looked at records which supported the provider to monitor the quality and management of the service, including audits, accidents and incidents reports, complaints and quality monitoring reports.

Requires Improvement

Is the service safe?

Our findings

We had concerns shared with us from a healthcare professional about the management of people with diabetes. The healthcare professional told us, "I have concerns about the qualified staff managing risks for people with diabetes as they do not seem to have the knowledge about the risks. I also have concerns about the current lack of a clinical lead here as there seems to be a lack of clinical oversight and support to the nurses". The healthcare professional provided examples of having to raise with qualified nurses that the emergency box to be used when a person had hypoglycaemia was empty, records detailing if insulin had been administered were not always completed and nurses were not always following the agreed management plan for people to ensure their diabetes was being managed safely. We were also advised that where someone's blood sugar levels were low, action to address this was not always being taken in a timely manner to ensure the person was safe. Although the provider had taken action in response to the concerns raised by the healthcare professional they had not identified these areas of risk. We were advised by the provider that during the absence of a permanent clinical lead, a clinical area manager provided support to the service.

People and the representatives we spoke with told us staff supported them safely with their personal care and when using moving and handling equipment. One person told us, "The staff use a hoist and I feel safe when they transfer me, they explain what they are doing throughout the procedure". We observed staff using equipment and this demonstrated safe practices were followed. We found staff were aware of risks associated with supporting people and the action they should take to reduce these. For example, staff told us how they monitored people's skin when there was a potential risk of pressure sores, and how they supported people who were at risk of choking. We saw people had risk assessments in their care files which identified some of the potential risks relating to their health needs. These included risks related to their mobility needs, support with assistance to eat a meal and the potential risk of damage to skin due to pressure.

However, we saw not all health related risks had been identified, and recorded effectively. For example, we reviewed the management of the catheter support provided to people. We found assessments were not always in place which detailed risks associated with supporting people with catheters. This included risks presented to people due to spinal injuries. We found staff were not following current guidance by the National Institute for Health and Care Excellence (NICE) in relation to catheter care management and the recording, draining, and changing of catheters. This meant some of the risk assessments and care plans in place had not been completed in accordance with best practice guidelines to ensure people were supported safely and to reduce the possible risk of infection. In response to a recent safeguarding incident the provider had reviewed their policy in relation to catheter care management.

We received mixed feedback about the availability of staff to meet people's needs. One person told us, "I think the staff are very busy, but they meet my needs when I need them to". Another person told us, "Sometimes when they are short staffed due to sickness I may have to wait a little longer but on the whole I think there is enough staff to meet my needs". A representative told us, "I think the staffing is enough to meet my relative's needs". Another representative said, "I think they are short staffed, they are always very

busy ". We also received mixed feedback from staff who told us that at times depending upon the day more staff support would be beneficial. Staff told us when staff telephoned in sick this did have an impact especially when their shift could not be covered. We saw occasions where the deployment of staff impacted on the support people received, for example, we saw one person that wanted to leave the lounge area was asked to remain in the lounge as a staff member was not available to support the person when walking so to keep them safe. On another occasion one member of staff was supporting five people while two staff had their break together. The provider advised us that staff should not have breaks together and this issue would be addressed with staff.

The care staff were supported by one qualified nurse on each shift. We found due to the clinical needs of the people living in the home, this was not always sufficient during day time hours. The home did not have a clinical lead currently employed to provide support to the qualified staff when this was needed at busier times. The provider advised us they were currently recruiting a clinical lead and they had devised a contingency plan to ensure clinical support could be provided to the qualified staff until a suitable clinical lead was recruited. We saw a dependence tool was in place and the service was staffed in accordance with this. The acting manager told us that the dependency needs of people were reviewed regularly to ensure sufficient staff were available.

People told us they received their medicines when they needed them. One person said, "Yes the staff give me my medicines when I should have them". Another person said, "I have no issues with my medicines I get these when needed and if I am in pain I am provided with pain relief".

We looked at the management of medicines. We found people received their medicines as prescribed except on one occasion when a medicine error had occurred. We received a notification prior to our inspection about this medicine incident where qualified nurses had administered an increased dosage of medicine to a person over a period of five days. The provider took action once this error was identified and we were advised that the person suffered no ill effects due to the increased dose. While an assessment of medicines competency had been undertaken following this incident, this had not been completed by a nurse. We raised these concerns during our inspection and the provider addressed this. The provider had also arranged for the nurses to attend medicines training. Where people had medicines on 'as required' basis, staff had the knowledge to recognise when people may need this medicine. We found that senior staff administered medicines in addition to the nurses. The senior staff we spoke with confirmed they had received medicines training and an assessment of medicines competence. We saw that although weekly and monthly medicines audits were completed and actions were taken to address the shortfalls found, these audits had not identified all of the shortfalls that had been identified by visiting healthcare professionals.

Some people could at times demonstrate behaviours that may present challenges to staff. Staff we spoke with had knowledge of how to recognise when people's anxiety increased and the strategies needed to divert and reassure people during these times. One staff member told us, "We use diversion strategies and there are protocols in place for us to follow so that we are consistent in our approach. We monitor and record any incidents and share these with the manager".

People we spoke with told us they felt safe, but some did not always feel their property was safe. One person said, "The staff do not mistreat me in any way, I would not accept this and I would raise it with the manager if I felt they were being disrespectful or abusive". Another person told us, "I feel safe when being supported by staff but I have had things go missing". We had received a notification about this and an investigation had been completed. People told us that they were able to have a key to their room if they wished and some people confirmed they had a key and a lockable facility in their room. Representatives we spoke with told us

they felt people were safe from abuse. One representative said, "I have no such concerns and if I had any suspicions I would raise this immediately". Staff were aware of the different forms of abuse and the action to take if they had any concerns about people's safety. They also confirmed they had received safeguarding training. One staff member said, "I would report any concerns straight away". We checked people's finances and found the money held in safekeeping was accurate with the records in place.

The provider told us that a recruitment policy was in place and that checks were undertaken before staff worked in the service. One person told us, "I assist the provider with the recruitment process and I take part in interviewing perspective new staff which I am really enjoying". We checked three staff files and saw all of the required recruitment checks had been undertaken before staff started work.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found improvements were required as staff did not have the required knowledge about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Not all staff were aware of which people had authorisations in place where their liberty was being restricted for their safety. On this inspection we found that although some improvements had been made further improvements were required.

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.

We saw where people were being deprived of their liberty in their best interests, applications had been submitted to the appropriate supervisory body and for some people these had been authorised. We reviewed all of these authorisations and the conditions imposed within them. We found the provider was not meeting the conditions on some of the authorisations we saw. For example, we saw that one of the conditions had been for the provider to arrange for a review with the Clinical Commissioning Group (CCG). This condition was imposed on an authorisation dated 2014 which had expired and a new application had been submitted. The provider was not able to provide us with evidence this review had been requested until after our inspection. Another condition was for the provider to devise a personalised activities programme for a person. When we reviewed the programme in place and the activities records, we saw staff had not supported the person to participate in the activities detailed in the programme. We discussed our findings with the acting manager and area manager. They took action and a new personalised activities programme was devised with the service's occupational therapist and implemented for staff to follow. Care records were updated for people to include information about the conditions and how these should be met.

Staff we spoke with had knowledge about which people had DoLS authorisations in place but they were not fully aware of the conditions imposed on some of these authorisations. We saw information displayed about these conditions was incorrect. We raised this with the acting manager who amended the information recorded to ensure staff had access to the correct information to enable them to support people in the least restrictive way.

During our discussions with staff concerns were shared with us about an occasion when someone's freedom of movement between the floors of the home was restricted. We shared this information with the acting manager who completed a safeguarding referral and confirmed an investigation would be undertaken into these concerns.

During our discussions with staff they demonstrated a good understanding about the principles of the MCA. During our observations we heard staff asking people's consent before providing support. One person told us, "The staff always gain my consent before providing me with support. I am involved in my care and make decisions about my daily life". We saw people were given choices about daily events, such as the clothes they wore, the care they received, the food/drinks they consumed, and how they wished to spend their time.

People and the representatives we spoke with told us they thought the staff had the skills and knowledge to support them. One person said, "I think the staff seem to know what they are doing, I have no concerns about their skills and abilities". A representative told us, "I think the staff have the skills and knowledge for their role".

Although staff had received training in several areas we found not all staff we spoke with had knowledge about a condition that people were at risk of developing due to their spinal cord injury. We discussed this with the acting manager and area manager who were able to provide us with information fact sheets about this condition which were provided in people's files. However, we highlighted the lack of some staff knowledge about the condition and we were advised that formal training would be provided.

Staff told us they had completed an induction when they first started their employment in the service. One staff member said, "I am currently completing my induction and I have several on-line courses to complete as part of the Care Certificate. I am shadowing staff at the moment to get to know people's needs and routines". The Care Certificate is a nationally recognised induction process which provides a set of fundamental standards for the induction of adult social care staff. Another staff member told us, "I have completed many training courses over the years of working here and in the areas relating to the specific conditions people have, for example acquired brain injury and epilepsy". Some staff said they would like to complete sensory awareness training to help them to fully appreciate the impact of visual impairment on a person's life. This information was shared with the acting manager who advised this training would be arranged. We saw that several training sessions were planned for the next few months, and some staff had attended mental health training during our visit.

Care staff confirmed they had received supervision and we saw a supervision programme was in place. One staff member said, "I feel supported in my role and I have regular supervision so I can discuss any issues I have. I have also had an appraisal where we discussed my performance and development needs". Nurses told us they felt supported by the manager and they confirmed that they had received clinical supervision from other nurse managers based within the provider's other services. All nurses we spoke with confirmed that having a clinical lead employed at the home would be beneficial to support them in their role and to provide clinical oversight within the service. A nurse told us, "I do feel supported and as we work alone on each shift there are times when I need to consult someone about clinical issues so I do call my peers. It would be beneficial to have a clinical lead here onsite to provide support on a daily basis".

People told us and we saw that rehabilitation plans were in place for each person. We were advised that since our last inspection there had been changes to the therapist team due to staff leaving. People told us that this had impacted upon them accessing the rehabilitation kitchen for a period of time but things were now improving as a full therapist team was now in place.

Most people we spoke with were satisfied with the food provided. One person said, "I like the food it meets my needs and cultural requirements. I can have snacks when I want and I have plenty of drinks to keep me hydrated". Another person said, "There has been changes to the catering staff and sometimes I am not keen on the food provided, but I have shared my thoughts at the last meeting we had and I know there are new menus that will be implemented very soon which we have agreed". A representative we spoke with told us

"[Person] really enjoys their food and tells us they like the food provided and they have plenty of snacks. Staff are always making sure people have enough to drink as well". We sat with people during their lunchtime meal and we saw menus were not always displayed on the tables to enable people to see what options were available. We were advised a menu book was available in the lounge area for people and staff to refer to. We also saw one occasion where staff had not prepared for the meal. For example, cutlery was not laid out and available for people to use meaning people had to wait for this when their meal was provided. We also saw chairs were not made available to enable staff to sit with people when assisting them to eat and this was only done when people's lunch arrived.

We saw people were supported in a dignified manner to eat their lunch. People had the equipment needed to independently eat their meal for example; adapted cutlery and plate guards were provided. We spoke with the head cook who had a good knowledge of people's preferences, cultural and dietary needs. The cook told us that the provider was currently recruiting catering staff to assist her in the kitchen as the previous staff had left. During this period of time and when the head cook had a day off we saw the kitchen and cooking duties were covered by care, domestic and administration staff. We were advised that all staff had completed food hygiene training. We saw one member of staff assisted the cook, and when we checked their training record they had not completed food hygiene training. We raised this with the acting manager who advised that the staff member was only providing support with washing up and not with food preparation.

We saw there was a system in place to monitor any risks to people from not eating or drinking enough. Referrals to the doctor, speech and language therapist or dietician had been made to ensure risks were reduced. Plans were in place to guide staff and nurses to ensure people received sufficient nutrition and hydration and records were completed to monitor what people received where this was needed. We saw that where people were at risk their weight was monitored. However we did see that records of people's weight were not always completed consistently and in accordance with the intervals identified in their risk assessments for example, every month.

People told us they were supported to maintain their health care needs and to attend medical appointments. One person told us, "I can see healthcare professionals whenever I need to and the staff assist me with this. I see the GP, dentist, and optician and various consultants when I need to". A representative told us, "The staff do arrange medical appointments but at times I am not always informed about these so I can attend to". Another representative shared some concerns with us about a recent appointment they had attended. We were told that the appointment was arranged by the service but the staff member who supported the person to attend did not know the purpose of the appointment, and therefore had not taken the required records. This led to a telephone call being made to the nurse in charge at the service to enable the parent and staff to gain this information.

Requires Improvement

Is the service caring?

Our findings

Although we received comments from people and their representatives who told us that staff were caring in their approach there have been incidents when people had not always received support which demonstrated a caring approach. For example a person did not feel staff were caring when due to a lack of communication during a handover period they were left unsupported during a personal care task. The person told us this left them distressed and upset. The support provided to people in relation to meeting their healthcare needs has also not been consistently caring as people have not always received the support they had needed to manage their needs.

People and the representatives we spoke with were complementary about the staff. One person said, "The staff do a good job and they are kind and caring and we have a laugh which is good". Another person told us, "The staff provide good care and they are kind and helpful." A representative we spoke with told us, "The staff are much better than those in the last home. They are kind and caring in their approach and respectful when they talk to [person]".

We saw staff interacting with people and noted that they listened carefully and responded appropriately. Staff were respectful when communicating with people. We saw positive interactions between people, staff and visitors and relatives. For example, one person was becoming upset and then their facial gestures changed to smiles when a staff member approached them to provide support and reassurance. We saw people greet staff with smiles and hugs when they first saw them which demonstrated they had developed positive relationships with them. One relative told us, "I have a good relationship with the staff they are so welcoming when I visit and they make sure I am okay as well as [person] they all brilliant".

We saw staff encouraged and involved people to make decisions wherever possible. One person told us, "I discuss my care needs on a daily basis with staff and they provide the support I want and need. I am involved in my care and the staff work in accordance with my wants and needs". Another person said, "I make daily choices about what I want to do and the clothes I want to wear and the staff support me with this. They help me with my makeup and jewellery and they provide reassurance when I need it especially when I become anxious about things". We saw many examples of how staff provided choices to people throughout the day in relation to their daily life.

We heard staff speak to people respectfully using their preferred methods of communication. Staff were patient in explaining tasks to people and gave people time to process the information before making choices. We saw some people were able to communicate verbally using certain words and other people used pictures, objects of reference or communication boards. Staff were responsive to people's communication needs which demonstrated that staff knew people well. Information was provided in people's care records detailing their preferred method of communication to assist staff when engaging with people. We saw that people's care records were being developed in a format which was accessible to the person and this was an area the provider intended to develop further.

A person told us, "I have lots of equipment to assist me to be as independent as possible; this makes my life

easier and gives me satisfaction that I do not have to depend on other people all the time". A representative told us, "The staff encourage [person] to do as much for themselves as possible so they do not lose the independence they currently have". We saw that people had rehabilitation plans in place which included a range of goals that the person wanted to achieve with set timescales. These were personalised to people's needs and abilities. We saw that these plans focused on how to support people to retain their independent and for other people their aspirations to gain further skills to become more independence in their daily life and mobility. We heard from the occupational therapist team how they were currently completing new assessments with people so that plans could be reviewed and implemented in order to maximise people's potential in their daily lives.

People and representatives told us their privacy and dignity was maintained and respected. One person said, "The staff support me in a dignified way and when I want some privacy the staff respect this". A representative said, "From what we have seen there have been no issues with the way staff support [person] they always look presentable and staff support them to maintain their appearance in the way they used to before their injury". We saw that staff were discreet when supporting people with their personal care needs and assisted people to the toilet or to their bedroom to undertake these tasks. Staff were mindful when supporting people with food or drinks to ensure any debris was removed or their clothes were changed if needed. We saw people were supported to dress in accordance with their individual styles and preferences.

The provider told us in their PIR there were no restrictions to the times people could see their visitors. We saw notices displayed asking visitors to be respectful of mealtimes so that this did not impact on the support people received. A representative told us, "I can visit when I want and sometimes I stay and assist [person] to have their meal as I enjoy doing this and the staff are fine with this. There are no restrictions and I am always welcomed into the home by the staff and the managers".

People were supported to access the services of an advocate when this was required. We heard that some people were currently using an advocate service to support them to make decisions about certain aspects of their life. An advocate is an independent person who supports people to make their own informed decisions. We saw that information about advocacy services was displayed in the home for people and their relatives to access.

Requires Improvement

Is the service responsive?

Our findings

We received information from a healthcare professional both during and following our inspection informing us of their concerns about the management of people's diabetes. The information they shared has demonstrated that some people were not receiving personalised care that was responsive to their needs. For example the healthcare professional visited the service on a regular basis and provided advice and guidance to the nurses about the on-going management of people's diabetes. Following recent visits to the home the healthcare professional has shared concerns whereby the advice they have provided has not been embedded and followed by the nursing staff to ensure they were responsive to people's medical needs. This has resulted in two safeguarding referrals being made to the local authority.

People and their representatives told us they had involvement in their initial assessments and care plans when first using the service and this was confirmed by records we saw. However some people said their on-going involvement was not consistently maintained. While people told us that they were involved in how their care was planned and delivered on a daily basis, they were not always involved in the monthly reviews that were undertaken. One person told us, "My family and I was involved and consulted during the assessment that was undertaken and when my care plan was developed. I know that I can see my care plan whenever I wish, but I was not aware that this plan is reviewed on a monthly basis and this is not undertaken with me". Another person told us, "I am involved in the formal reviews but not always in the monthly reviews that are undertaken". It was not always clear from people's records whether or not they had been involved in all of the reviews of their care. We saw instances when care records were reviewed by night staff (at times when people would usually be asleep) which meant people could not be consulted or participate in all of the reviews undertaken. We did however see evidence that showed people had been involved in the meetings held about their rehabilitation plans, where their goals and aspirations had been reviewed and new ones agreed and set where required. The provider told us that monthly reviews were untaken by both night and day nurses on an evaluation process to identify if needs required changing or were on-going. People would be involved in the monthly reviews if there was a change in need and their care plan was to be updated.

People and representatives said they knew how to make a complaint and they had confidence any issues they raised would be dealt with. One person said, "Any issues I have raised have been addressed to my satisfaction, the staff and manager have been very responsive in respect of this". Another person said, "I have not raised any formal concerns I have raised an issue today and I am confident this will be dealt with and action taken. I have raised some of my opinions in the meetings we have and I have received satisfactory responses". A representative said, "I am aware there a procedure in place, if I had any concerns I would discuss these with the manager and I am confident these would be dealt with.

Following our inspection we received some information of concern about the care provided to a person and we were told these concerns were shared with the acting manager before our inspection. We discussed this with the acting manager who advised us about the action they had taken in response to the concerns which had been shared with the complainant. However when we reviewed the complaints record during our inspection we did not see that the initial concerns had been recorded and the action that had been taken.

We discussed this with the acting manager who told us that as the complainant was happy with the response she did not feel it was necessary to formally record their concerns. The acting manager confirmed that this would be addressed and the complaint would be formally recorded. We did see that other complaints had been recorded and the action that was taken to address these.

We observed that staff were responsive to people's needs. One person told us, "The staff do help me when I need them to and they are responsive to my requests. They provide reassurance when needed and emotional support". A representative said, "I think staff are responsive and they do their best to ensure people's needs are met the way they want them to be met". We saw how staff responded quickly when a person was in distress and they provided immediate and on-going support to that person.

People told us that staff continued to attend to their needs and considered their preferences. One person said, "I am able to do what I want to do and it is based on how I feel that day". Another person told us, "I choose how I spend my day and I if I want to go out the staff do facilitate this for me as I may need support at times".

People were supported to maintain their personal relationships with people who were important to them. Records provided information for staff to refer to about people's life history, cultural background and their sexual orientation.

People told us that they pursued their own interests and hobbies. One person said, "I do a lot of work on my computer or attend college or watch TV. I choose not to mix and attend any of the activities provided by the activities staff but I know things are planned daily". Another person told us, "I enjoy going out and going shopping and the activities staff support me to do this as well as going for meals, to the cinema, theatre or to the pub, anything we want to do we can. I do sometimes find weekends a little boring as not much happens then or when the activities staff are not here the care staff don't usually have time to support us with activities".

The activities co-coordinator told us their emphasis was about supporting people to go out and access community facilities. They told us about the forthcoming fete that was being arranged and we saw people went out with the activities staff member to visit local businesses to ask for donations for their fete. We saw a board was displayed with identified the various in-house activities that could be provided this ranged from arts and crafts, movement to music, to film nights. People continued to have access to the cinema, games and sensory room that was also available on site. We saw that coffee mornings were provided in the rehabilitation kitchen which gave relatives an opportunity to meet with the acting manager to discuss any issues. We also saw that a Huntington's Disease awareness day had recently been facilitated.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 in relation to good governance of the service. In December 2016 we completed a focused inspection which demonstrated that the service had made the required improvements at that time to meet the requirements of the breach. We found on this inspection these improvements had not been maintained.

During our inspection in December 2016 we found the registered manager and deputy manager (who was also the clinical lead) had left the service and a new non- clinical acting manager had been appointed. We were also informed that some care staff and staff from the therapist team had also left the service since our last inspection. This meant that the area manager has been the only consistent manager that has been providing support to the service since our last inspection.
The provider had not recruited to the deputy manager's post and they had appointed a clinical lead in November 2016, but this staff member left in April 2017. This meant since April 2017 the acting manager has been managing the service without a clinical lead or deputy. The acting manager advised us she had received support from the provider and from the clinical area manager. We were also advised that support could be sought from the clinical leads based in the nearby homes. We have received an application from the acting manager to register with CQC.

Since our last inspection we had received information of concern from the local authority about the safeguarding incidents that had occurred at this service. Due to these concerns the local authority had suspended the provider from accepting any new referrals.

There have been a number of issues of concern in relation to the clinical management of people's medical needs. These concerns have been shared with us by healthcare professionals that had visited the service while providing support to people with their healthcare. These professionals have told us about the potentially negative impact on people due to the provider's lack of clinical oversight and auditing processes. For example, people's diabetes not being managed effectively placing them at risk of harm, and the delay in identifying a medicine error. We found records were not always completed to demonstrate the clinical support provided to people. For example, recording when insulin was administered to people on a consistent basis as required by people's management plans. We found that although weekly and monthly medicine audits were completed these were not effective in identifying shortfalls. For example the blood glucose machine was not being calibrated before use. These issues had been identified by a visiting healthcare professional who then shared these concerns with the provider to enable them to address these shortfalls. The provider's auditing systems should be robust enough to identify such shortfalls without input from external professionals so as to ensure people are kept safe.

We identified other shortfalls during this inspection which we had identified during previous inspections. For example, staff not aware of conditions on DoLS authorisations, staff not trained in areas specific to the needs of the people they support, fluid monitoring records not being completed accurately and records of action taken when optimum levels where not provided. Discussions with staff, nurses and representatives

demonstrated communication processes in the service had deteriorated recently. For example, we heard of a concern raised with a nurse about a staff member's performance which they had responded to and dealt with. This information was not passed onto the acting manager to ensure they were aware of the issue and to enable on-going monitoring of the staff member's practice. This has now been addressed by the acting manager. We found that the audits completed by both the acting manager and provider had identified some but not all of the shortfalls we had identified. Where identified, actions were formalised to address these issues. Other issues had not been identified, for example, records to support that conditions on the DoLS authorisations were being complied with. This showed the provider's quality audits were not robust and effective.

We have found that although the provider has taken immediate action to address issues of concerns and shortfalls the approach has been reactive as opposed to being proactive. For example during our inspection we found that when we identified shortfalls the registered manager and area manager took action to address each issue to make the required improvements in the service. However this action was taken in response to our findings and not in response to shortfalls being identified from the internal audits and systems that were in place.

This is the third time the provider has been rated as Require Improvement. We have found that although some improvements have been made in response to our findings and inspection reports these have not been sustained and embedded.

We found the provider was in breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Relating to good governance.

Following our inspection visit the provider has told us that they had appointed a clinical lead to support the nurses and the acting manager and to provide clinical oversight within the home.

People and representatives told us the acting manager was approachable, friendly and visible in the home. One person said, "She is very nice and always takes time to come and say hello and ask how I am. I think she is settling in well. The manager comes into the lounge and I see her walking about checking on people. She is doing her best to manage this home and I think she is an open and honest person". A representative said, "She is lovely, approachable and listens to what I have to say. I see her walking about the home and her office door is pretty much always open".

Staff said they generally felt supported by the management team. One staff member said, "The manager is approachable and I feel able to go to her and she is supportive. I think she is doing her best to manage this service for the good of people". Another staff member said, "I am happy in my role and I do feel supported by the manager and the provider. I know that I can go to them with any issues and they would listen". Staff told us there had been many staff changes in the service recently and this had impacted on the atmosphere and culture. One staff member said, "We have had a change of management and new staff start so it takes time for things to settle down. The atmosphere here is still okay and we all are working together. The communication needs improving more so we all have the same information and the same aim". Staff confirmed that regular staff meetings were held and handovers were completed following each shift. However we found staff rotas did not take into account the time required for a detailed handover and there was no overlap of staff on duty. Therefore we found staff came on shift early in order to be part of the handover.

Staff we spoke with confirmed a whistleblowing policy was in place and they felt confident to use it and share any concerns. A staff member said, "A policy is in place and I would feel confident to raise any

concerns I had about other staff members practices". Whistleblowing is the process for raising concerns about poor practice.

Systems were in place to obtain feedback from people, representatives and staff about the service provided. These included regular meetings with people and their representatives and quality assurances surveys were sent out. We reviewed the results from the recent surveys completed in May 2017. We saw that positive comments were received and suggestions and areas for improvements were also identified. We saw that an action plan had been developed to address any suggested areas for improvements.

The provider told us in their PIR that routine checks were completed to ensure the premises were safe for people, for example checks of fire systems, health and safety and maintenance of equipment. A sample of these checks confirmed this. We saw that accidents or incidents were monitored for any patterns or trends. This included any incidents of people's behaviours that may challenge staff that occurred. The acting manager took action in response to these as necessary by reviewing care records and completing referrals to healthcare professionals. The provider met their legal duty in respect of notifying us about events required to by law. This showed that they were aware of their responsibility to notify us so we could check that appropriate action had been taken.

At our last inspection in May 2016 we rated the service as Requires Improvement. The provider is required to display this rating of their overall performance, on their website and conspicuously in a place within the service where people can see it. We were able to see the rating displayed at the home and on the provider's website.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) HSCA 2008 (Regulated Activities) Regulations 2014 People who used the service were at risk of inappropriate or unsafe care because the provider did not have effective systems to assess, manage and monitor risks.

The enforcement action we took:

Warning Notice