Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14, 15 and 16 May 2018 and was unannounced. The Dean Neurological Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Dean Neurological Centre provides accommodation for 60 people who require personal care with nursing. There were 47 people living in the centre at the time of our inspection. The centre provides personal care and support to people with complex long term neurological conditions, brain or spinal injuries and people who require on-going support and assistance to maximise their functional ability. The centre is purpose built and set over two floors, each floor comprising of 30 individual bedrooms, communal lounges and dining rooms. On the ground floor there is a therapy department, sensory room and people have access to several decked areas in the garden.

Following our last inspection in June 2017, we met with the provider and asked the provider to complete an action plan to show what they would do and by when to improve the key questions in the domains of safe, effective, responsive and well-led. At this inspection we found that progress had been made in the recording of people's care needs, the delivery of personalised care and the monitoring of the service to drive improvement. However further improvement was still needed as people's care records were not always current and some people did not always receive personalised care.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However an interim manager had been allocated to the home by the provider to support the registered manager to drive improvement across the home. The centre was also being supported by specialist internal and external advisors as well as representatives from the provider.

Systems and initiatives to monitor the service were being implemented. Through their own quality assurance assessments, the provider had identified concerns in the running of the home and was acting on these shortfalls. However we found that their systems had not always identified gaps in the recording of people's current needs and the delivery of personalised care. We have recommended that the service seeks advice in designing and reviewing people's support to ensure that it reflects their needs and preferences. Systems were being put into place to gain the views of relatives and staff and improve communication and assess the quality of the service being provided.

Relatives and staff had been concerned that people had not always been supported by staff who were familiar with their needs. A high turnover had resulted in people being supported by agency and/or new staff who may not have a sufficient understanding of their care requirements. The centre was actively recruiting

new staff and plans were in place to implement an effective management structure and keyworker system to help to assist with the monitoring of people's needs and care records.

People were supported to access health care services when their medical needs had changed and received their medicines as prescribed. We received mixed comments about the quality of food people received, however we found that people's dietary needs and choices were catered for.
We found the centre was clean and free from offensive odours. The provider was in the process of employing additional housekeeping staff to maintain the level of cleanliness on a daily basis and reduce the risks of cross contamination.

People and their relatives were positive about the staff who cared for them. Staff ensured that people's dignity and privacy was respected, although people did not always have access to social and meaningful activities. However action was being taken to address the environment and activities in the centre.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this 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?

Good

The service was safe

People's risks had been identified and were managed in accordance to their needs. People's medicines were managed safely.

People benefited from a service where staff understood that people should be protected from harm and abuse.

Agency staff were used to support people when there were gaps in the staffing levels. Staff were safely recruited.

Is the service effective?

Good

The service was effective.

Staff were working within the principles of the Mental Capacity Act.

Records indicated that people had been referred to the appropriate health and social care professional when needed.

People were supported to maintain a balanced diet.

Staff received training and support that helped meet people's needs.

Is the service caring?

Good

The service was caring.

We saw staff interactions with people were positive and caring.

People and their relatives were positive about the caring approach of staff who supported them.

Staff respected people's dignity and privacy when supporting them with their personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always reflect their current needs. Staff might therefore not always have all the information they need to know how to provide individualised care to people. Further recorded details about people's personalised back grounds, end of life care and best interest decisions were needed.

People's personal and social needs were not always being met. Action was being taken to address the issue of the home's environment, garden and activities in the home.

The management and communication about people's concerns had not always been effective for some relatives, although other relatives felt their concerns had been explored in a timely manner.

Is the service well-led?

Requires Improvement

The service had not been consistently well led.

A new management team was in post to support staff and to improve the service being delivered. The interim manager was being supported by representatives of the provider. Systems were in place to monitor the care being provided however further improvement was needed to consolidate and embed the systems to drive improvement.

The centre was actively recruiting new staff and plans were in place to implement an effective staffing and management structure.

Systems were being put into place to gain the views of relatives and staff and improve communication.

The Dean Neurological Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14, 15 and 16 May 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience and knowledge of caring for people with a disability.

Before the inspection we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. During the inspection we spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people and four people's relatives. We looked at 11 people's care plans and associated records. We also spoke with eight care staff, four nurses, the therapy manager, an activities coordinator, two maintenance staff , the quality improvement lead, the interim and registered manager. Several representatives from the provider also spoke with us including a clinical matron manager, a clinical infection control lead and the general manager. We received feedback about the centre from four health care professionals and the commissioners and local authority.

We looked at files relating to staff development and recruitment. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Good

Is the service safe?

Our findings

At the last inspection of the Dean Neurological Centre in June 2017, we rated this key question as 'requires improvement'. This was because complete and accurate records of people's care and treatment were not always available for staff to know how to keep people safe. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014. At this inspection in May 2018, we found the provider had taken the required action and the service met the requirements of this regulation.

Risks associated with people's clinical needs and physical well-being had been assessed and individual risk management plans had been put into place to reduce the potential for harm. For example, the management of risks associated with people's skin integrity, nutrition and respiratory care were recorded to give staff the guidance they required to support people. We observed that staff had a good understanding of safety procedures and the management of risks associated with people's daily care and clinical needs.

Accidents and incidents were reported to the registered manager and recorded on the provider's central electronic system. The incidents were reviewed by the clinical governance team to establish if there were any patterns or trends in the type of incidents that had occurred. When incidents relating to people's well-being had occurred, staff were required to reflect, identify and undertake additional training if gaps in their knowledge had been found.

People received their medicines as prescribed. Their medicines were ordered, stored and managed safely. Since our last inspection the provider had worked with a pharmacist and had comprehensively reviewed and had taken action to improve the management of people's medicines. The nurse on duty for in each floor took responsibility for administrating people's medicines. We looked at a sample of medication administration records and found at people had been given their medicines as prescribed.

The service was using safe practices in the monitoring and recording of the stock control of the home's controlled drugs (CD) in line with the provider's medicines policy. CD's are medicines which have been classified and could be dangerous if misused by others.

The registered manager told us the staffing levels were based on people's support needs and the funding they received from local authorities to support some people to receive one to one care. Feedback from staff and relatives suggested that the staffing levels had not always been kept at the required levels, especially if there had been unplanned staff absences. Records showed staff had carried out additional shifts or agency staff were used when there had been staff shortages as the centre had recently experienced a high turnover of staff. Staff told us there had been times when they had been short staffed but they had worked together as team to support people. One staff member said, "Sometimes we are ok and there is enough staff but on other days we can be really short. It puts pressure on us but we always make sure everyone is taken care of." Staff explained that the use of agency staff had impacted on the care provided as some agency staff were not always familiar with people's needs. The managers explained that where possible they had requested to use agency staff who were familiar people and the centre's processes. The provider had provided specialised respiratory care training to some agency staff to ensure they were adequately skilled to care for

people with respiratory needs. The registered manager was actively recruiting new staff and had recognised that further work was needed to ensure that all agency staff supporting people had the skills required to support people with complex needs.

Records relating to the recruitment of staff (including nurses, care staff and other staff) showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. Since our last inspection the centre were checking the recruitment histories and documents of all staff to ensure people were supported by fit and proper staff.

People were kept safe from the risk of abuse or harm. Staff told us they had received safeguarding training and were aware of the different types of abuse. The provider had recently engaged with the local authority to deliver additional safeguarding training sessions on top of the mandatory safeguarding training for staff. Safeguarding was also discussed at staff supervision sessions which helped to ensure staff understood and followed correct processes to keep people safe. Staff were clear of the provider's safeguarding procedure and their responsibilities to report any suspicions of abuse and whistle blow if they had any concerns about people's safety and the quality of care. One staff member explained, "I am very clear on what I would do if I thought anyone was being harmed in anyway by anyone." We followed up on the actions that had been taken when safeguarding concerns had been raised and were reassured that appropriate actions had been taken to safeguard people. The provider had also signed up to a new safety programme for all staff. We were told that staff would be provided with a 'frame work' to safely challenge clinical behaviour' and encourage all staff to 'speak up for safety' when there were concerns about people's well-being and welfare.

Progress was being made to develop and embed robust infection control practices to prevent the risk of infections in the centre. During our inspection we found the centre was clean and free from offensive odours. Staff had access to personal protective clothing such as gloves and aprons and were observed using these appropriately. The provider was in the process of employing additional housekeeping staff to maintain the level of cleanliness on a daily basis and reduce the risks of cross contamination.

Two staff members had been engaged to become leads in infection control with the aim to monitor the standards of hygiene within the home and improve the infection control practices amongst staff. The infection control leads had protected time to audit the infection control practices of the home and report their findings to the provider's infection control committee. The provider's infection control clinical lead had also visited the home and provided additional support to embed and advise on current infection control practices. They explained that best practices were being reinforced to all staff to help reduce risks. This included the ongoing review of infection control practices to ensure people's equipment associated with people's respiratory care were cleaned and stored safely.

Good

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act and whether any conditions on the authorisation to deprive a person of their liberty were being met. 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 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).

Staff had a basic understanding of the principles of the MCA relevant to their role and supported people to make day to day decisions based on their knowledge about people. For example, we observed them providing people with choice about their care such as where they wanted to sit in the lounge. People's mental capacity had been assessed in relation to the daily support they received from staff at The Dean Neurological Centre. The managers and staff provided several examples of when decisions had been made in people's best interests. The registered manager had applied to the local authority for those people who were being deprived of their liberty and was waiting for the outcome of their decision.

People's care was assessed and planned in line with recognised guidance. The registered manager had assessed people's physical, clinical and emotional support requirements before they moved into the home to ensure they could meet their needs. People's risks had been assessed using nationally recognised assessment tools which assisted staff to understand people's risks, goals and their support requirements. The centre had worked with specialist internal and external health care professionals to help to embed best care practices. Some people had experienced positive outcomes as a result of the homes practices such as improving their mobility, respiration and sitting tolerance. Since our last inspection the home had commissioned a specialist consultant nurse to provide on-going guidance and support for people who required invasive ventilation and respiratory support . Their aim was to optimise people's respiratory care and minimise their risks.

We received mixed comments about the quality of food people received, however we found that people's dietary needs and choices were catered for. People's dietary needs and any changes to their likes/dislikes and weight changes were communicated to the head chef. They also told us they were informed of when people had lost weight and required their meals to be fortified with extra calories such as using full fat milk, cream and butter for food such as mashed potatoes and soup. Two choices of hot meals and dessert were provided at lunch time and alternative lighter meals made available to people when requested. People's care plans provided staff with information about people's nutrition and hydration needs. We observed people were given specialised and textured diets as recommended by the speech and language team.

Staff worked with the internal multidisciplinary team and external health care professionals to ensure people's health and well-being was being monitored and maintained and met in an emergency. Staff or

relatives helped to support people to appointments as required. The service was in the progress of implementing a hospital care plan which would provide hospital staff with essential information about people's clinical, social, medication and communication needs. We were told that the centre had implemented an NHS Red Bag initiative for one person to assist with a safe transfer into hospital. They explained the "Red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with resident."

The local GP surgery frequently visited the centre and managed people's general medical needs. People's care and treatment needs and their progress were discussed at the monthly multi-disciplinary team (MDT) meetings with key staff from the centre including the therapy staff and significant external health care professionals. Health care professionals informed us that they felt some improvement had been made in the records, monitoring and communication from the centre in their specialist areas and staff were willing to learn and implement their recommendations.

Staff received a range of training which was relevant to their role. They told us they felt supported and trained to support people who lived at the centre. The centre was supported by a training co-ordinator who planned, delivered some training and monitored the training of staff. New staff were inducted into the service and were required to read the centre's policies, procedures and shadow an experienced colleague. They carried out training in areas such as manual handing and safeguarding and their competencies and knowledge were assessed using a 'care standards' supervision tool. New staff were also required to undertake a national qualification in health and social care which included all elements of the care certificate. Progress was being made to ensure nurses and leads had received enhanced training in their areas of specialism. We looked at the staff's training matrix which indicated that most existing staff had received regular updates in their training. However the provider was aware that further work was needed in the management of staff rotas to allow them to have protected time to undertake refresher training to ensure all staff remained current in the relevant care practices.

Tools used to assess the competencies of staff in specialised clinical areas were being reviewed and implemented. Plans were in place for staff to be further trained in the management of people's respiratory care and implement competency assessments in all specific and appropriate areas of care including emergency care.
The premises was well maintained and spacious which allowed easy wheelchair access and to move people in their beds around the home. People had been consulted about the decoration of the centre. Their suggestions had influenced the planning and decoration of the corridors in themes such as the forest, rugby and update the garden/patio area.

Good

Is the service caring?

Our findings

People were cared for by staff who were compassionate and dedicated to their role. The atmosphere in the centre was calm and relaxed. We observed that people felt comfortable around staff and there were many warm and kind exchanges amongst staff and people. Most of the staff team had a good knowledge of the people they supported including their life histories and the people who were important to them. Relatives told us they were welcomed to visit their loved ones and had built up a strong relationship with staff. One relative said, "I come here every day. I watch what is going on. There are some good staff here. Some work hard and communicate with me. Others could learn from them."

Not everyone at the centre could or wanted to communicate with us, however those who wished to speak to the inspection team told us staff were kind and caring. Their comments included: "They are very nice", "Yes I like the carers, you can a laugh with some of them. They are like my friends" and "They are OK, some are better than others. Mind you, you can't click with everyone so it's generally not an issue for me." One person expressed, "When it is good here it is really, really good, when it is bad it is not terrible."

On one of the days of our inspection it was one person's birthday. People and staff sang happy birthday to them when they entered the lounge in the morning and gave them a birthday card and present. We spoke with the person later in the day who told us they were very pleased that their birthday had been acknowledged by the staff.

Staff respected people's privacy and dignity. We saw staff knocking on people's door before they entered and asking them discreetly if they needed support with their personal care. Staff closed people's doors while supporting them with their personal hygiene or providing any clinical interventions. We observed one staff member supporting one person to the toilet and then waiting outside the toilet to give them privacy. Staff were attentive to people's needs and ensured they were comfortable. People were asked if they were warm enough or asked their preferences to sit away from the direct sunlight. Staff supported people with individual requests such as shopping if their families were not available to support them.

Staff understood people's communication needs and used technology to assist people's ability to communicate where required. One staff member said, "You get to know the people who stay here very well. For some that can't talk, we have to look at the body language to try and understand if they are happy or in pain or interpret their way of communicating with us." The managers informed us that people at the centre were treated equally and that staff were aware not to pass judgement and to respect and support people with their personal values and beliefs and other protected characteristics. Most staff had completed training in equality and diversity.

People's bedrooms had been decorated with personalised items and belongings which reflected their interest and items which were important to them such as football shirts or cultural objects. People's care plans emphasised the importance of treating people with dignity and respect. Staff offered people choices about their participation in activities and where they wished to spend the day.

Some people choose to join others in the communal areas or spend time in their bedrooms. Others were taken by staff to the communal areas as part of their sensory and social stimulation. People enjoyed spending time in the sensory room to help stimulate their senses. A sensory room is a specially designed to help people stimulate and engage their senses within a safe environment.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection of the Dean Neurological Centre in June 2017, we rated this key question as 'requires improvement'. We continued to find shortfalls in records associated with people's care and told the provider they needed to make the required improvements by 18 October 2017. At this inspection in May 2018, we found the provider had taken action to address our concerns, however further improvements were needed to fully meet the regulations to ensure people's records contained all the information relating to their individualised care.

Since our last inspection the provider, registered manager and staff had acted on our concerns about the quality and detail of people's care records and had reviewed the format and updated each person's care records. We found that most people's care plans were personalised and reflected their needs and goals and provided staff with the information they needed to support people's physical and emotional well-being; however we found that further improvements were needed in the accurate recording of people's changing needs to ensure their needs would be met.

Whilst people's risks had been recorded, their care plans had not always been updated to provide additional guidance to help prevent future incidents occurring when people's health had deteriorated. For example, one person had a clear tissue viability care plan in place to help to guide staff on how to mitigate and prevent a break down in their skin; however the tissue viability or percutaneous endoscopic gastrostomy (PEG) management plan had not been updated when they had developed a minor wound around the site of their PEG tube. Whilst a treatment plan had been recorded, the care plans had not been updated with a revised plan of the management of care to help mitigate further risks of the skin breakdown around the PEG site. We also found that the use of new monitoring charts had not been fully implemented for some people which could cause confusion for staff and put people at risk of not receiving safe care as different monitoring charts were being used by different staff.

Staff told us that they were confident that the care being provided at the centre was personalised and focused on people's individual support needs. They provided many examples of how they have supported people personally to improve their quality of life and wellbeing such as shopping for people, escorting them on trips in the community and speaking to them about personal interests. Progress had been made to the personalised care that people received, however further improvement was needed to ensure that people's care plans were accurate and reflected their current needs. For example, one person was drinking from a different cup that had been recommended by a health care professional and was stated in their care plan. This was raised with the registered manager who provided us with the rationale behind the change in their cup to meet the person's evolving needs, however this had not been fully recorded.

Another person's care plan stated they required thickened fluids although staff told us this was no longer required. Another person's drinks were being thickened but with another person's thickener. Staff stated another person no longer required their blood sugars to be taken daily however this had not been updated in their care plan. It had been recorded for one person that a healthcare professional had recommended that they were 'multi drug resistant', however this information had not informed the person's care plan in

relation to the risk management and treatment of potential infections, although it had been recorded that the healthcare professionals would take the lead with prescribing medicines.

Improvement had been made to the recording of people's mental capacity assessments and their consent to care however further improvement was needed in the recording of best interest decisions made on behalf for some people. For example, one person had been assessed as being at high risk of falls and staff had arranged for sensor equipment to be put into place to help reduce the risk of harm and alert staff if they began to mobilise. However this best interest decision when the person could not consent to the use of this equipment had not been recorded.

End of life documentation was available to each person as part of the new care planning format, however we found that details about people's end of life wishes had not been completed for some people. A health care professional shared with us the importance of each person having an end of life care plan in place as people who lived at the centre were vulnerable due to their complex medical needs and that a comprehensive end of life care plan would benefit people and their families and help reduce any unnecessary admissions into hospital. Personalised information would help to direct staff of people's end of life wishes if their needs suddenly changed to ensure they had a personalised, comfortable and pain free death. For example, although staff were aware of end of life management plan for one person it was not evident in their care plan if their preferred wishes, end of life plan, symptom management and liaison with their family had been discussed. The managers explained that staff had developed good links with end of life healthcare professionals but they were aware that further improvement was needed in the recording of the planning and the outcome of their discussions with families and specialist palliative care team to ensure people had clear end of life care plans to guide staff.

'All about me' booklets about people's backgrounds and preferences had been implemented as part of the new care planning but had not been completed for everyone as yet. Therefore staff who were unfamiliar with people's backgrounds and preferences may not have the information they needed to help them to socially interact with people who had limited communications. We were told this was a 'work in progress'. We found that permanent staff knew people well and were observed talking to people about their interest and family. They told us how they engaged with people who were unable to communicate and were at risk of social isolation. However, the registered manager could not always be assured from people's care records if their social needs had been met because staff did not consistently record people's engagement in activities or social interactions.

Further improvement was needed to ensure people's care plans are updated to reflect current changes in their needs, best interest decisions and end of life care. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we found no negative impact on people, the discrepancies in the care being delivered and information provided in people's care plans meant staff that did not know people well might not have up to date information about their needs and preferences.

Since our last inspection, the centre had made progress in ensuring people received personalised care based on their preferences and backgrounds, however this improvement had not been sustained and embedded for all people. For example, some relatives shared with us concerns that people's individual care needs were not continually being met by staff. Most felt that this was a result of agency staff who were not fully aware of people's personal requirements and preferences. One relative explained that they found it frustrating to have to explain to new or agency staff the preferences and details of the care that their loved one required. We found that people's cultural dietary needs had not always been met. For example, one

person shared with us "I don't get the food I like to eat. I know I can't have it every day. There is food I have which doesn't agree with me. No one has asked me about my likes or dislikes from catering." The person's care plan did not provide details on their cultural needs and dietary likes and dislikes. There was no evidence of how the service had identified ways to meet this person's cultural needs. It had been recorded as part of one person's therapy goals that they should enjoy monthly trips in to the community and within their DOLs conditions that staff should contact and research cultural organisations to ensure their cultural beliefs were being met, however we found no evidence that these personalised needs were being met.

When we looked at the way staff were deployed around the centre and on different floors, it was clear that some areas of the centre required more support. For example, we found that people who had been funded for one to one support had the staff support that they required, however other people and relatives told us staff did not always have time to spend with people. From our observations of staff, we found that some people who stayed in their bedrooms received limited engagement and interactions from staff other than to support them with their personal care. For example, one person was at risk of social isolation. Staff had identified that due to the mobility needs of the person and their own preferences that they tended to remain in their own room. The person was able to communicate their needs and stated, "I would like to have someone to chat to and discuss things with." While staff had identified this risk, there was no evidence of the support they had provided to meet this person's wellbeing needs.

We have recommended that the service seeks guidance and support from reputable sources on designing and reviewing people's support to ensure that it reflects their needs and preferences.

We discussed our findings with the provider who explained that through the restructuring of the clinical team, the nurses will have additional time to ensure all care plans were current and reflect people's needs to help mitigate the risk of harm. The recruitment of permanent staff would also ensure that people would be cared for by staff who were fully aware of their personalised needs. However, we have been told that since our inspection feedback a front page is to be added into each person care plan to provide staff with a quick overview about their backgrounds, interests and likes and dislikes and were reviewing the handover systems to ensure all staff were familiar with people's needs. The provider had also identified that people's specific needs needed to be monitored and had engaged with some staff to become leads in specific areas such as nutrition and medicines. We were told they would be given time to enhance their knowledge and monitor the service being provided in their specialised area with the aim to monitor the recording of people's care, drive improvement and make staff more accountable for the care they delivered.

The centre employed two activity coordinators who arranged and provided a range of activities in the home such as external singers, trips into the community such as boat trips, horse riding and visits to the garden centres. They explained that they and other staff also provided activities to people individually. The provider had recognised that people's social and environmental needs were not always being addressed. Records showed that staff and people had been consulted about future activities, events and items in the centre which would enhance people's lives such as fish tanks, garden club, a choir and beauty salon. A monthly 'fun committee' of both people and staff had been developed for people to express their views and opinions on matters which are important to them and make suggestions about other activities in the centre. For example, plans were in place to develop a sensory garden. The centre was also engaging with volunteers and forming links with the local community.

Some people received funded therapy as part of their care package to improve their physical and mental well-being. The therapy team consisted of a physiotherapist, occupational therapist, speech and language therapist and provided people with individual funded programmes of therapy. The therapy manager told us their team was passionate about supporting people to reach their potential. They were working hard to

ensure that there was joint working between the therapy and care staff to ensure that people's therapy needs were being continually met. The therapy manager also explained that people's therapy was person centred and focused on their therapy goals which also interlinked with people's interest and backgrounds. Plans were in place for a care staff member to be seconded part time to the therapy team with the aim to educate care staff about integrated working and to reinforce the importance of embedding people's therapy goals into their daily support. Some members of the therapy team were implementing a tool to assess and rehabilitate people with prolonged disorders of consciousness to identify their functional and communication abilities. The therapy manager explained that this was an accredited process based on national guidance.

Some people who live at the centre live with long term complex needs such as long term assisted respiratory care. A specialist nurse commissioned by the provider explained that their aim was to ensure that staff were skilled to support people with their respiratory needs, improve people's quality of life and ensure their safety. The centre had successfully weaned three people from invasive ventilation and working with two others. The specialist nurse visited the centre quarterly and stated that "Staff are always eager to learn and develop their practice."

People and most of their relative's told us they were able to openly discuss any concerns problems with the staff and managers at the centre. They felt their concerns and complaints were explored and responded to in good time; however two relatives stated they did not feel that their complaints were managed well. They both explained they had lost confidence in the management of the centre. This was discussed with the provider who assured us that action was being taken to review the management structure which would provide a clearer structure for people and their relatives to report their concerns to and also improve communications to relatives. Any formal complaints were logged on to the provider's central electronic system and reviewed and actioned by the senior management team.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of the Dean Neurological Centre in June 2017, we rated this key question as 'requires improvement'. We continued to find shortfalls in the effectiveness of the auditing and monitoring systems being used to drive improvements across the service. We told the provider they needed to make the required improvements by 18 October 2017.

At this inspection in May 2018, we found the provider had taken action to improve quality assurances systems and improvements were being made to the service. Further time was needed to ensure that the systems to monitor and improve the quality of people's care records and the delivery of personalised care were always effective in driving improvement s for all people. Therefore we have continued to rate this domain as 'requires improvement' and the service remains in breach of the standards of the regulation relating to recordkeeping. Since our last inspection an interim manager had been appointed to manage the centre, improve the quality of care and support the registered manager. They explained that they felt, "Staff had lost direction and confidence was needed to be instilled into staff" and went to explain how they were supporting and encouraging staff to build their confidence. The provider had recognised that the structure and responsibilities of the managers and senior staff needed to be reviewed to ensure a fair distribution of work and accountability in the centre. The provider was currently reviewing and recruiting new staff at all levels to implement their vision of the staff structure to enhance people's well-being at the centre.

The provider's senior management team had good oversight of the service and had closely monitored the service and had sought external expertise and resources to help improve the quality of care and the running of the centre. They were working on a combined action plan and implementing various initiates to help motivate staff and embed good care practices such as developing specialist leads.

The managers of the centre had also been regularly working and liaising with external agencies such as commissioners and local authorities to help monitor the quality of care being delivered. Senior managers met regularly as part of a clinical governance committee to review issues relating to the people's welfare and clinical needs such as reviewing any accidents and safeguarding and clinical concerns. The committee had recognised areas of good practice such as medicines management but had also highlighted areas that required improvement including improving the hand over system between staff and being more inclusive with people and relatives.

The provider had not always assured that people's person-centred needs and care were being met and monitored. The quality improvement lead had supported the service to implement the new care plans and audit the care being provided and drive improvement. For example, regular audits were carried out of the management of people's percutaneous endoscopic gastrostomy (PEGS), care plans and medicines. Any shortfalls were shared with the nursing staff and managers. However we found that some areas of the auditing system needed to be reviewed and embedded. For example, people's care plans were regularly audited however they had not identified some discrepancies in the care beginning provided and the recording of people's care needs. People's life histories and end of life care plans had not been consistently completed. The medicine's audits had not identified that there was inconsistencies in people's protocols for

medicines which had been prescribed some to be used 'as required'. We raised these concerns with the managers who said they were aware of some of the inconsistencies in relation to people's care records; however their plans to implement a keyworker system would help to address these concerns.

The therapy team were implementing audits to ensure their recommendations of care and support were continually being implemented by care staff such as the monitoring of people wearing their required splints to prevent muscle contractures.

Clear and effective systems were in place to monitor and maintain the premises, utilities and equipment associated with people's care. The provider had taken immediate action to ensure that all their premises met the regulatory fire standards and had introduced a comprehensive fire safety and monitoring tool. Health and safety and infection control audits were carried out to ensure the centre's environment remained safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans did not always reflect current changes in their needs, best interest decisions and end of life care.