Cheer Health Limited

London Road Neurological & Specialist Care Unit

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 23 and 24 January 2017 and was unannounced.

London Road Neurological and Specialist Care Unit provides accommodation for up to 33 people who require personal and nursing care. The service provides care for people with an acquired brain injury as well as for people with degenerative conditions. At the time of our inspection there were 19 people using the service.

The previous comprehensive inspection of 2 and 4 February 2015 found the service to be compliant with the regulations.

The service had a registered manager. 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.

We found improvements were needed in some aspects of people's medicine. Medicines were stored safely and securely in the service. People in some instances were prescribed medicine to be taken as and when needed, we found insufficient information within their records to ensure nursing staff administered the medicine consistently, and with guidance to enable staff to identify the effectiveness and a person's response to the medicine. Where medicines were not given orally but via a tube direct into the person's stomach then the administering of these medicines was not consistent with good practice. The registered person and registered manager advised us they would liaise with the relevant health care professionals to ensure medicine systems were reviewed to ensure they were being given safely.

People's safety and well-being was promoted through the pro-active management of risk. This was achieved through the sharing of information and agreed strategies for promoting people's health and welfare. And through the employment of sufficiently trained and experienced staff to meet people's needs.

The provider had a comprehensive induction and on-going training programme, which reflected all staff roles and responsibilities. Staff were encouraged to continually develop their professional expertise, which included health care assistants attaining qualifications in care. All staff had their competency to perform their role and specific tasks regularly assessed and they received further support and guidance through supervision and appraisal.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were committed in their approach to supporting people to make informed decisions about their care. Assessments to determine people's capacity to make informed decisions about their care had been undertaken. Where people had been assessed as not being able to consent their family members and supporting health care professionals

documented the care they believed the person should receive after considering their best interests.

People and their relatives were involved in the development and review of their care needs, which included all aspects of their care. We found people and/or their family members had in many instances agreed that they should not be revived through cardiac pulmonary resuscitation and the appropriate forms were in place to support this decision.

People were supported to have sufficient to eat and drink and had their individual dietary needs met. Where people had their nutritional needs delivered by a route other than by mouth, staff had the appropriate training to provide this aspect of people's care.

Staff were proactive in responding to people's health care needs, through timely communication amongst themselves and through contacting the appropriate external health care professionals involved in people's care. People using the service and their family members were at all times fully involved in all aspects relating to people's health care.

The atmosphere of the service was calm. People using the service and their family members spoke positively as to the attitude and approach of all staff and their willingness and openness to listen to them and talk with them about their health issues. Staff had a comprehensive understanding of people's needs and their role and responsibility in ensuring people received the care and support they needed, which they provided in a safe and respectful manner, whilst promoting people's privacy and dignity.

There was an open and inclusive approach to the assessment of people's needs. Staff from the service met with the person and their family to assess the person and to speak about the service they provided which gave an opportunity for people to ask questions. Family members were encouraged to visit the service prior to their relative moving in, to help them to decide whether the service was right for them. People and their family members were continually involved in the updating of people's needs and reviewing of care plans.

People were confident to raise concerns or make a complaint; complaints which were received were fully investigated consistent with the provider's policy and procedure. The provider used complaints and concerns to make any necessary changes to the service to ensure they provided good quality care.

The registered person, registered manager, and all staff were committed to meeting the needs of people using the service and providing support to their family members. This was achieved by an open and inclusive approach to family members and those receiving a service, through on-going dialogue and through the on-going review processes of people's needs.

The provider had quality assurance systems that were robust. The proactive approach to good governance meant information gathered through quality audits was used to continually develop the service and looked for ways in which people using the service could be confident that they received good quality care.

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 consistently safe.

We found improvements in the administration and recording of people's medicine was needed in specific areas of medicine management.

People were protected from abuse and avoidable harm as staff fully understood and implemented the provider's policies and procedures.

Risks to people's health and wellbeing had been assessed and were regularly reviewed with measures in place to ensure staff supported people safely.

The provider had a robust recruitment, induction and training policy and procedure which ensured there were sufficient experienced and skilled staff employed to meet people's needs safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who undertook training and had their competency regularly assessed to ensure they had the appropriate knowledge and skills to enable them to effectively carry out their role and responsibilities.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The open and inclusive approach of the service meant people and their family members were involved in making decisions about all aspects of their care and support.

People were supported to maintain their health through the appropriate intake of nutrition and hydration, which included where people received their nutrition via the use of specialist equipment.

People were referred to the relevant health care professionals in

a timely manner. People and family members were involved in all aspects of their health, which included where decisions were made not to attempt to resuscitate a person.

Is the service caring?

Good

The service was caring.

People who used the service and their family members were supported by staff that had developed professional and supportive relationships which focused on an inclusive approach to care.

People who used the service and their family members were supported to express their views, which were facilitated by the open door policy of the management team and the accessibility of staff.

People received care by staff that recognised and understood the importance of involving people in their care and the promotion of people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received care, treatment and support that reflected their assessed needs, which were regularly reviewed. People and their family members were involved in all decisions about the care and treatment provided.

The provider had a complaints procedure which was accessible to those using the service and their family members.

Is the service well-led?

Good

The service was well-led.

The registered person, registered manager and management team were highly visible in the service and were open to being approached by people using the service, their family members and staff.

A registered manager was in post. The registered manager, management team and staff had a clear view as to the service they wished to provide which focused on the delivery of high quality care. This was achieved as the registered person ensured staff were continually supported by the continued development of their skills through training and on-going assessment.

Monitoring systems, which included a range of audits, were used to check the quality and safety of the service being provided, which included the maintenance of the service and its equipment.

London Road Neurological & Specialist Care Unit

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 the 23 and 24 January 2017 and was unannounced.

The inspection team comprised of an inspector, a Specialist Advisor and a member of the CQC pharmacist team. The Specialist Advisor had experience working and caring for people with an acquired brain injury and degenerative conditions.

We contacted commissioners for health care who fund the placements of people at the service and asked them for their views.

We reviewed notifications we had received from the provider. Notifications are information about key incidents and events within the service that the provider is required by law to tell us about.

We spoke with two people who used the service and four family members who were visiting their relatives. A majority of people using the service due to their health care needs were unable to communicate or express their views.

We spoke with the managing director (registered person), general manager, and registered manager, training nurse manager, three nurses, five health care assistants, the activity organiser and the chef.

We looked at the records of five people, which included their plans of care, risk assessments and daily notes. We looked at nine people's medicine records. We also looked at the recruitment of three members of staff,

staff training records, quality assurance audits and the minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

A member of the CQC medicines team reviewed the management of medicines and looked in detail at the medicines and records for people using the service. Records were kept of medicines received into the service and given to people, these were completed fully. The medicines section within people's care plans was not always completed as we did not see information relating to a person's preference in medicine taking.

Medicines were stored safely and securely in the service including medicines requiring refrigeration. Medicines with a short expiry when opened were dated to ensure staff would be aware when these were no longer suitable to be used. Controlled drugs, (which are medicines that require extra records and special storage arrangements because of their potential for misuse) were stored and recorded in line with regulations.

Some people were prescribed medicines on a when required basis. We found that people's records had insufficient information to show the nursing staff how and when to administer these medicines or the responses to treatment they should observe. This meant people may not have received their medicine in a consistent way and when it was needed. The registered manager of the service and staff members told us that the workforce was stable; members of staff knew people well and could assess their need for when required medicines. This was confirmed by the inspection team through questioning of both nursing and healthcare staff.

Of the nineteen people using in the service, thirteen were having their medicines administered directly into their stomach through a tube and the necessary safeguards were not in place to administer these medicines safely. We saw that staff were administering these medicines in accordance with the policy held by the service but this did not ensure medicines were given safely. We found medicines were being mixed in water prior to administration and there was a risk that incompatible medicines would be mixed and become ineffective.

We observed people being given their medicines by the nursing staff. When staff gave medicines via the oral route they followed good practice and signed medicine administration records (MAR) charts after the person had taken the medicine. However, we saw that when medicines were being prepared to be administered via a tube into the stomach the medicines were signed for on the MAR chart before being given to the person which is not in line with safe practice. A member of nursing staff told us that these medicines may be prepared up to an hour before the person was given the medicine and left unattended in the person's room. This would result in an incorrect entry on the chart should a person be unable to have the medicine administered when it became due. This could also result in degradation of the medicine prior to administration which may affect efficacy.

Care staff applied topical creams and ointments to people's skin. We saw that there were records in place to support these creams being applied safely and consistently in line with prescribed frequencies. Labels did not always include details of where creams needed to be applied but nursing staff were aware and the

topical administration records included this detail.

Some people had medicines given via a skin patch, although staff were able to describe the correct process for selecting a suitable site of application there were no records to show this was being done. Where MAR charts had been handwritten we saw that on most occasions these had been double signed by two members of nursing staff to ensure accuracy.

We looked at how the service protected people and kept them safe from potential abuse or avoidable harm. The provider's safeguarding (protecting people from abuse) policy was displayed throughout the service and provided staff with guidance as to what to do if they had concerns about the welfare of any of the people who used the service. Discussions with staff showed they had a good understanding as to what action they would take if they believed somebody was being harmed or abused.

Staff we spoke with referred to the policy and confirmed it was strictly adhered too. Staff told us an aspect of the policy was for two staff at all times to provide support and care for people, to promote their safety and welfare. Where ancillary duties were carried out such as cleaning, then staff left the person's door open whilst their room was cleaned.

Visitors to the service were welcomed; however staff ensured they knew who visitors were before allowing them to meet those using the service. We heard a member of staff greet a visitor. The member of staff asked the visitor who they were there to see and the nature of their visit, upon receiving a response they were asked to sign the visitor's book.

We asked staff how they promoted people's safety, they referred to each person having risk assessments in place which provided information as to how potential risks were to be minimised by staff. Staff spoke about the regular observations they undertook to ensure people were well so that action could be taken if needed. Staff we spoke with were aware of the need to risk assess each situation themselves and take responsibilities for their actions, to ensure people's safety was promoted.

People's records contained risk assessments which covered a range of topics to promote people's safety and welfare. Risk assessments were regularly reviewed and updated and reflected people's care plans. Staff we spoke with were aware of potential risks to those using the service and themselves and were aware of the need to report any concerns to a senior staff member about risks affecting people's care or their surroundings. Staff undertook training in risk assessment and care planning and understood how the two different documents worked together to promote people's health, safety and welfare.

A person we spoke with told us they felt safe, when staff used equipment to enable them to move safely. They told us the physiotherapist was working with them to increase their independence in standing and walking. They went onto say that the physiotherapist was providing training for staff so they would be able to deliver the same support and care safely.

People's records contained an assessment which determined whether they could summon staff help by using the call bell system. Where people had been assessed as not being able to use the system then half hourly checks were carried out by staff to monitor the person's health and welfare. This was consistent with the provider's policy and procedure. During the inspection we found call bells were responded to quickly by staff.

Risk assessments were in place for people who were unable to re-position or mobilise themselves and who were reliant on staff to ensure their skin remained intact and they did not develop areas of redness or sores.

These assessments were regularly reviewed, and provided clear instructions for staff, which included instructions on the frequency of re-positioning people and the use of equipment where appropriate, which included specialist bed mattresses and cushions for chairs. We were advised by the registered manager and nurse training manager that no person at the service had developed a pressure sore. Staff were trained and equipped to treat pressure sores as some people when they moved into the service already had a pressure sore. Staff liaised and were supported by external health care professional with specific areas of expertise.

We asked staff how information about people's safety and welfare was shared. They told us staff handovers took place when staff arrived on duty and all those using the service were discussed, which included where changes in people's health and welfare had been identified. Staff told us that any changes in a person's condition which required additional checks and monitoring to be carried out was discussed so that everyone understood their role and responsibility.

We spoke with the registered manager about staffing levels within the service; two nurses worked during the morning, supported by six health care assistants. In the afternoon and evening one nurse was supported by four health care assistants, and at night a nurse and three health care assistants provided people's care. Staffing was flexible to meet people's needs, for example where people required one to one care and support or where staff were required to accompany people to routine hospital appointments, then additional staff were made available.

Staff told us there were sufficient staff to meet people's needs. We found a significant number of staff had worked at the service for many years, which provided a stable nursing and care team. Staff told us there was not a staff recruitment or retention problem. One health care assistant told us, "In the 6 months I have worked here I have never known a shift not to be covered with the full staff numbers required." To promote people's safety, the provider told us staff were paid for their breaks, and remained on site so they were able to respond to any emergencies.

People's safety was supported by the provider's recruitment practices. We looked at staff recruitment records and found that the relevant checks had been completed before staff worked at the service, which included a check as to whether nurses were registered with the appropriate professional body. Records showed that the registered person and management team followed the provider's disciplinary procedures where staff were found to be providing care which was not of the standard expected by the provider.

Good

Is the service effective?

Our findings

Staff upon commencing work had a comprehensive induction programme. The first three days were spent with the nurse training manager familiarising themselves with policies and procedures and the philosophy of the service. Staff induction included training in specific areas, such as the moving and handling of people and the correct use of equipment. All staff spent time with experienced staff, reflective of the role they had applied for, to enable them to understand their role and were for the period of their induction not included within the staff compliment.

The nurse training manager during a member of staff's three month induction carried out competency assessments of their work to ensure they were confident that the member of staff was able to fulfil their duties safely. Health care assistants completed the Care Certificate during their induction. The Care Certificate is a set of standards for staff that upon completion provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. The nurse training manager following the member of staff's induction period would write to the director to advise them as to whether the person had successfully completed the induction programme. Where people's competence was not assured a decision was made as to whether additional time was to be spent in supporting the member of staff. Upon a person's completion of the induction period a contract of employment was made.

The nurse training manager continually assessed staff competence throughout their employment. The training provided was both practical and theoretical and took place at the bed side of people where appropriate, in groups or within the training room. Training was also sourced externally from organisations with specialist knowledge. Nursing staff undertook training specific to their role, and received updates on their Code of Practice requirements and the revalidation of their competence to remain registered with the Nursing and Midwifery Council (NMC). Health care assistants undertook vocational qualifications in care. Of the eighteen health care assistants employed, sixteen had attained a vocational qualification at level 2, with four staff having also obtained level 3. This showed the provider's commitment to providing good quality care through effective and on-going investment in staff training.

Additional support was provided through staff supervision (one to one meeting) with a member of the management team and annual appraisals. These provided an opportunity for staff to discuss their role and talk about their future training and development. We found staff training to be impressive and very thorough and from discussions with staff and paperwork viewed this had a positive impact on the standard of care provided.

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 and nursing homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found where conditions on authorisations were in place these were being upheld. Records showed people in some instances who had a DoLS had regular meetings with a 'paid person's representative' (PPR). The PPR monitored the implementation of the DoLS and as part of their role they spoke with staff and viewed the person's records which detailed how staff implemented the DoLS conditions.

We found people's competency to make informed decisions about key aspects of their day to day care and support was considered, consistent with the MCA. This ensured people's human and legal rights were respected. People's care plans provided clear information as the support they needed, and included the tasks people could undertake themselves to ensure their independence was maintained. Where people's ability to complete tasks for themselves fluctuated dependent upon their health, this was documented to ensure the support provided by staff was effective.

In some instances people had made an advanced decision about their care with regards to emergency treatment and resuscitation, which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This had been put into place with the involvement of the person, their relative or representative and health care professionals. Where the person themselves had not been able to share their views the decision arrived at was undertaken in the person's best interest. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

Staff made best interests decisions in line with legislation for people which were recorded on an individual basis. One example was how information about people's moods and facial expressions was considered and recorded by staff and understood as communication by the person in the expression of their views. The pattern of people's moods was used to aid potential treatment and re-assessment of people's care and was accessible to people's visitors as an aid to understanding communication. A member of staff told us how a person with no verbal communication expressed pain so that pain relief could be accessed on behalf of the person. They told us the person would move their head and then staff would point to areas of the body until the staff identified the correct location of the pain.

People's records included risk assessments with regards to nutrition and hydration. Assessments of people needs and care plans provided clear guidance on the maintaining of people's nutritional and hydration needs. These were regularly reviewed, which included the monitoring of people's weight.

A number of people using the service were able to eat and drink in order to maintain a balanced diet and we found nutritional assessments had been carried out. We spoke with the chef and found that people's dietary needs and preferences were known by them and were catered for. The cook was aware of specialist diets to be catered for, which included vegetarian, diabetic, high protein or high calorific diets. The chef also had information as to people's food allergy intolerances as well as their likes and dislikes. In some instances people were prescribed supplements to maintain a healthy nutritional intake. We looked at the menu, which identified the choices available to people and whether people required a soft diet, to reduce the risk of choking. The chef told us that there were no budget restrictions on the purchasing of food and that all foods were bought fresh and meals made on site.

Visiting family members told us they brought in food in some instances, where their relative had made a

specific request. The provider and registered manager told us, that whilst they were happy to provide any specific requests, the involvement of people's family in a person's care was welcomed. One person told us, "I always have drinks available to me throughout the day and I am encouraged to drink all the time."

A number of people using the service received their nutrition via an alternative method, which included via a feeding tube known as percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG). Records showed dieticians prescribed the regime for people who required feeding via a tube.

Staff were supported by procedures and policies for different nutritional methods and the importance of eating and drinking to promote people's health, for example their skin condition. Staff recorded people's dietary intake and systems were in place to ensure records were completed timely.

A visiting family member told us how their relative's wellbeing had improved since they moved into the service over a year ago. They told us when moving to the service, their relative received their nutrition via a PEG and now having been assessed by a speech and language therapist (SALT) they now were able to eat a pureed diet, they said, "I have no complaints whatsoever."

People's needs were regularly assessed and reviewed and their care plans updated. Staff we spoke with spoke of the open communication between those using the service, their relatives, the registered person, registered manager and staff. This encouraged the reporting of individual needs in a timely and effective manner. We found people's relatives were involved in the care planning and assessment process. We spoke with family members who were visiting; they told us they were fully confident in the care their relatives received, which included the role of external health care professionals. Family members told us they were kept informed about any changes to their relative's health and any advice and information given by health care professionals.

One family member told us a consultant from a hospice had visited to review and speak with them about the medication their relative was taking. Another family member told us a doctor had visited to undertake an examination to review their relative. They said they had wanted to ask questions about their relative's health to find out the signs, symptoms and treatments available. They told us how the nurse had helped them to ask questions and to explain the options and implications available to their relative.

Staff confirmed they or people's family members supported them to attend external health care appointments where necessary. A GP undertook regular visits to the service and liaised with staff about people's treatment, this enabled an effective response to people's changing needs, for example the prescribing of antibiotics which were quickly ordered and administered to promote people's health.

People's care records showed people were supported by a range of health care professionals, which included speech and language therapists (SALT), dieticians, tissue viability nurses, specialist nurses related to specific conditions which included Huntington's disease, multiple sclerosis and Parkinson's. The service had a contract with a physiotherapist who provided support to people, which included referring people to specialist services for individualised equipment.

Good

Is the service caring?

Our findings

A visiting family member told us how their relative's wellbeing had improved since they moved into the service over a year ago. They told us when moving to the service, their relative had little speech. The person said, "They got him talking more by talking to him."

People who used the service shared with us their views. One person told us, "If I have to be in hospital I couldn't be in a better place." Visiting family members also spoke of their views of the service, which included the attitude and approach of staff. One told us, "15/10 as it is such a high standard at all times."

A visiting family member told us the registered person, registered manager and staff had helped them to understand the health needs of their relative, by spending time with them and explaining how the illness would progress. They said, "Staff looked after us, listened to us and we're able to now understand what's going on." They went onto say how staff listened to what they said and responded to their requests. For example, they had asked for their relative to wear particular shirts during the festive celebrations, and how staff had made a birthday cake for their relative, which family members could enjoy.

We observed throughout the inspection staff undertaking their duties, with respect, kindness and compassion towards using the service and visiting family members. Staff also showed a sense of respect towards each other. The atmosphere of the service was calm, despite quite intensive procedures which needed to be undertaken. The calmness of the service was as a direct result of staff working together as a team to provide co-ordinated care as all staff had a full understanding of people's needs. We spoke with staff about team working and communication. They told us, "It's the best team we've ever had. We work on honesty." And, "We always work in partnership, not just with each other but those we care for."

Staff shared with us, how getting to know people meant they were able to provide good quality care in a caring and supportive way. A staff member told us how they approached topics with a person, and understood that the way in which a question was phrased had an impact on the answer the person gave. Staff were told us that in some instances a smiling face was required to encourage people and provide reassurance.

Many of the nurses and health care assistants had worked at the service for many years, and in some instances had cared for people who had used the services for a long time. This meant staff had over time developed a comprehensive understanding of people's needs and their views. Staff were able to consider when the person due to a deterioration in their health was no longer able to express these themselves. We spoke with the registered person and registered manager about further developing people's care plans and records to fully reflect all that was known about people's lives and care. This would ensure any new staff had the opportunity to read and support people in a person centred approach to their care enabling staff to know the person as a whole and not just the support and care they needed. The registered person and registered manager told us they would look to further developing care plans to reflect a person centred approach to care.

Records were kept of the interactions between people using the service and staff to ensure that people's needs were known and understood and used by staff to observe for patterns of needs. This provided useful information to assist staff in anticipating people's needs so they could respond appropriately.

Upon moving into the service people and their relatives were advised that they could continue to receive support via health care professionals and others involved in their daily lives, who they were familiar with, which included doctors and dentists. One person told us they continued to have their hair managed by the hairdresser they knew.

Many of the people using the service, due to their complex needs were unable to communicate verbally or had the physical or mental ability to take part in activities. We asked staff how they considered people's needs for stimulation in these circumstances. Staff told us people were not left without stimulation, when in their bedroom, with entertainment being provided either through the television or through music.

Staff told us they always speak with people, to inform them about the care and support they were going to provide. Whilst delivering care and support staff would talk about current affairs and family members. Staff told us how they always worked in pairs to deliver care and how promoting people's dignity was key part of care. They told us they always knocked on a person's door before entering, and stating who they were before entering. Doors were kept shut when care was being delivered, and people's modesty was protected by ensuring people were appropriately covered during personal care.

The activity co-ordinator spent time with people, in most instances on a one to one basis, reading to people, providing hand massages and sitting and talking with them. For those people who could take part in activities, they told us they found out what interested them either from the person themselves or their family members. The activity organiser told us how they used this information to provide worthwhile activities, which people enjoyed. They spoke of how they played games with people, such as dominoes and how they had brought gardening into a person's bedroom, by helping a person plant flowers and care for them, which were later sold to raise money for charity.

Visiting family members told us they regularly visited. One person told us they visited every day and never felt restricted in their visits. They told us that they stayed until the evening and were always made to feel welcome, being regularly offered cups of tea. They went onto say they were confident that they could approach any staff member at any time for help and advice or concerns about their relative's needs. They told us how one evening when they were sitting with their relative, they appeared to 'black out'. They told us they activated the emergency call bell, and three members of staff immediately responded, who assessed their relative, and made sure they were both comfortable. Staff organised a visit from a medical professional for later that evening to see the person, where everything was explained to the person and their family member.

Visitors were welcomed into the service at any time between 10am and 8pm. Outside of these times people could still visit but were asked to let the staff know in advance where they could for the safety of those using the service, particularly at night.

A family member told us how their relative had not at the time of moving into the service had a shower or bath for many weeks, during their stay in hospital. They told us this had been a big concern to both their relative and themselves, which they spoke with staff at the service about. The family member told us staff were quick to respond, as their relative moved into the service in the evening and the following morning had a shower. This showed had staff promoted people's dignity and responded to their needs.

The registered person and nurse training manager told us about the links the service had with different religious and faith groups, who visited people at the service as per people's wishes and included the observance of religious practices at the time of a person's death.

We asked staff how training on end of life and palliative care informed how they cared and support people. A member of staff told us, "Empathy, tenderness and gentleness. If you have that humility it shows through. We're here to support the whole family."

Cultural, religious and spiritual needs were seen to be catered for people within the service and their family members. This was delivered through the training programme for staff and documented within people's care plans and records. There was a quiet room within the service which was available to people and open at all times. The service had an 'end of life' suite which was within a quieter area of the service, enabling people and their visitors to have quiet time together.

The right to complain for people and their family members was in place at any time and to any staff member should they wish. An open management policy that was seen in the service reflected this. A family member we spoke with told us they would not hesitate to bring any matter to the attention of staff. There was a formal concerns and complaints procedure in place at the service and this was detailed in the information booklet.

Good

Is the service responsive?

Our findings

Referrals to the service were received in a majority of instances via a discharge co-ordinator based within a hospital. The initial information was provided by telephone to establish whether the person met the criteria for London Road Neurological and Specialist Care Unit.

Family members we spoke with confirmed they had been involved in the assessment of their relative's needs and that they had visited the service before their relative moved in. One person told us, "[registered and deputy manager's names] did the assessment at Hinckley hospital." They went onto say they had been given the services information brochure, which provided the information they needed and that a member of staff had spent time with them explaining the service provided. We asked them why they had chosen this service, they told us this was because staff knew about their partner's health condition and had been able to spend time explaining to them the support and care that would be required.

The registered person, registered manager, deputy manager and nurse training manager undertake the assessment of a person and in a majority of instances involved family members. The assessment was always carried out by two staff and at the person's current place of residence, which in many instances was within a hospital setting. The assessment was used to determine whether the service could meet the needs of the person and the proposed costs of the care. The registered person liaised with all relevant parties to organise the admission of the person into the service.

A family member told us of their involvement in the development of their relatives care plan. "I have been involved in decisions about [person's name] care, I have spoken about the DNACPR and any medical interventions needed."

The assessment was used to develop care plans. Records showed where people were able to contribute to decisions about their care and these were recorded and included in the person's care plan. Where people did not have the ability to contribute, peoples' family members or significant others were involved. Care plans were in place in readiness for a person moving to the service to ensure people's care and support requirements was planned and any equipment required in place. This included the service having a dedicated bedroom and equipment, which included a bed that enabled staff to support a person with bariatric care needs (person who is obese).This ensured people's needs were met upon their admission.

There was a clear and consistently reported open communication policy from the registered person to all staff whatever their role. This was apparent from reviewing the training and care records and speaking to staff with various roles. We observed reporting and communication between staff throughout the day, which showed staff responded to people's needs.

Care plans were detailed and of a good standard. They were seen to be individualised and all risk assessments for moving and handling, eating and drinking, washing and dressing and other practical activities were seen to be up to date and re-evaluated on a regular and individual basis with recording of outcomes of these re-assessments and changes to practice/treatment required.

All staff stressed without being asked the importance of checking the care plans for changes not only at the start of the shift but regularly throughout the shift, as they were aware re-assessment and evaluation was an on-going process and treatments and care input changed for people on a very regular basis. However, it was seen that individual personalities and social needs and support were not detailed to the standard of the practical care needs and this was discussed with the management team. We were told that for some people it was not always possible to research their background due to the lack of records and information from people's families. However, they advised they would look at ways of incorporating such information to reflect the person centred care provided, where information was available.

The registered person had a complaints and concern policy in place. A complaint received in November 2015 had been investigated consistent with the provider's policy and procedure. The complainant had been given a written response, which included the action being taken to prevent a re-occurrence of their concern. This showed the service was open and transparent in dealing with people's concerns.

Good

Is the service well-led?

Our findings

We saw that family members of people who used the service, health care professionals and staff had completed questionnaires which sought their views about the service. We found the responses to questionnaires to be complimentary. The registered manager told us that where issues were identified within questionnaires these were dealt with on a one to one basis, we found any action taken had been documented. For example a family member had commented that they were not always offered refreshment when they arrived. This was raised with staff so that appropriate action could be taken.

The entrance foyer provided copies of the information brochure about the service, questionnaires for people to complete and record their views along with information about local services. The rating following the CQC's previous inspection was displayed. We found that the management team had a visible presence in the service and that they were available to people using the service, their visitors, visiting professionals and the staff employed. The open communication policy and atmosphere at the service was excellent and obviously understood and utilised by those using the service, relatives and staff.

There was a system to support staff, through regular staff meetings, supervision and appraisal where staff had the opportunity to discuss their roles and the development of the service and the care of people. For example, staff had been made aware of the revised policy for the use of bed rails and bumpers (which are used to prevent people from falling out of bed) following new guidance issued by National Institute of Clinical Excellence (NICE). Staff were made aware of the outcome of audits carried out and any actions that were to be introduced as result of their findings. For example, a chart for recording people's pain had been introduced to enable staff to gather information so that this could be shared with other health care professionals to ensure people's need were understood and met.

The registered person informed us they were at the service three days a week and were always contactable by telephone. Upon arriving at the service the registered person was provided with information, by the operations manager and registered manager about people's welfare and any other issues regarding the service. This meant the registered person had a clear insight to people's needs, which included any changes. This enabled the registered person and registered manager to make any changes to ensure the service delivered high quality care, for example by continually ensuring there were sufficient staff with the appropriate skills on duty to meet people's needs.

The strong sense of leadership provided by the management team was evidenced by the comments we received from staff. We asked staff for their views about the management team and the support provided. They told us, "I think, [registered manager's name] is fantastic. She wants a smooth running ship." "Managers are accessible and flexible to meet staff. We're supported through supervisions and appraisals; [registered person's name] is approachable as so is [registered manager's name. We're praised when we're working well." Staff told us members of the management team were always on hand to talk about aspects of people's care which were sometimes challenging, which included when people died. Staff told us they were supported to attend people's funerals, by the management team making changes to the staff rota.

The provider's commitment to high quality care was evidenced through its approach to the delivery of staff training, which applied to all staff irrespective of their role and responsibilities. The management team had taken the decision to appoint a longstanding nurse they employed, to the role of nurse training manager. They were not counted as part of the nursing team, which enabled them to carry out their role effectively.

Discussions with staff evidenced their commitment and passion to providing high quality care. We asked staff what they liked about working at the service. They told us, "I love some of the patients so much. I like the level of care we are able to deliver, delivering care to the max." "How professional it is here, and the homeliness we try to create." "If I didn't feel confident and happy about the standards of care and enjoy my work here I would not stay." And, "We provide good care; we care and treat people like family. They're looked after very well."

The provider had handbooks, which provided clear information for staff, about all aspects of the service, which included the philosophy of the service, the support and treatment of people, people's safety and welfare, people's rights to make decisions with regards to the MCA in relation to their care, information about nutrition and equipment used. The handbooks also provided information for staff about recruitment, supervision and training and how the provider monitored the quality of the service by seeking people's views. Our discussions with staff showed staff had a full understanding of the information contained within these handbooks and their role and responsibility in ensuring people received a high quality service.

We saw there were systems in place for the maintenance of the building and equipment. This included maintenance of essential services, which included gas and electrical systems and appliances along with fire systems and equipment such as hoists. A range of audits were undertaken by staff, which included twice daily checks on the environment to ensure the building was secure. The cleanliness of the service was considered with staff having specific areas of responsibility, which included the cleaning of identified areas within the service such as the treatment room and the cleaning of equipment, which included equipment for the moving and handling or people along with equipment such as drip stands and suction devices.

It was consistently reported by the staff to us that they had never had an instance where budgets were a problem and meant they were able to meet people's needs, which included the purchasing of equipment. An example was given where there was a person who needed to use a larger rotunda hoist for transfers for safety (the service already had a smaller one). The visiting physiotherapist had loaned a larger one to the service. The registered person to promote the person's health, welfare and safety was seen to have ordered the appropriate equipment, which they were waiting for delivery of.

The provider had had an assessment as to the quality of care being provided carried out by Leicester City Clinical Commissioning Group (CCG), for which they had a report that they shared with us. We contacted a representative of the CCG prior to our inspection to find out their views of the service. They wrote and told us that the service was very good at planning and delivering physical healthcare. They had identified some improvements could be made to the personalisation of people's care plans with regards to their emotional and psychological care. They stated they had no serious concerns about the care delivered.