

Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

About the service

The Dean Neurological Care Centre is a care home providing personal and nursing care to adults with complex and life changing neurological disorders. 44 people were in receipt of care at the time of the inspection. The service can accommodate up to 60 people.

The home was purpose built and people received care and therapy support in one adapted building. Each person had their own bedroom with washing and toilet facilities; they shared spacious communal areas. Outside there was an easily accessible decking area.

People's experience of using this service and what we found

People told us they felt more settled than when we last inspected. They were aware there had been changes in the management of the service and they spoke with us about the improvements they were aware of. People were generally happy with their care and had opportunities to discuss with staff areas they wanted altered.

Following our previous inspection, the provider had appointed an interim management team to drive their improvement plan and improve standards. We found the provider had effectively implemented their improvement plan and the improvements they had reported on every month were evident.

New and permanent home managers had recently been employed and time was needed for the new management team to get to know the service and to ensure all the planned improvements were completed.

Staff morale had improved, and staff spoke positively about working at the service.

Engagement with people and relatives was meaningful and extensive. Regular Residents Forums and surveys took place and we found lessons had been learned from complaints and incidents.

People felt safe and able to talk with senior staff if they needed to. Staff knew what action to take to maintain people's safety. Security measures were in place to keep people safe.

Risks to people's health, safety and the environment were assessed, monitored well and action taken to reduce these.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

People had access to medical and emergency support when needed. People's medicines were managed

safely.

People's complex care and treatment was reviewed regularly by specialist healthcare professionals. Visiting professionals told us the service had improved how it communicated with them about people's conditions and needs.

Some improvements had been made to people's care and treatment records. Professionals told us they had noticed this and could more easily find the information they required when they visited. Managers told us further improvements to people's records were planned.

Staff training, and support had improved, and they were supported to provide safe care and treatment to people which was in line with best practice guidance.

Staff had access to the information they required about people's care and therapy needs. Guidance for staff was now provided in a way which supported a person-centred approach to care.

People's care and therapy was reviewed regularly with them and their views and choices on this incorporated into the planning of their care.

Staff described a "wholesale change" in how care and therapy staff worked. A more collaborative way of working had been adopted and people had benefited from this.

Staff showed warmth and compassion towards people and were concerned for people when they were distressed or poorly. There was a genuine desire for people to live as well as they could and as comfortably as they could.

People were supported with activities they enjoyed, and, despite people's complex conditions and personal preferences, a great effort was made by staff to make these fully inclusive of everyone.

We observed staff interacting positively with people. People looked relaxed in the staffs' company. This demonstrated that important, supportive and meaningful relationships had been built between people and those who cared for them.

There were no restrictions on visiting and one person told us their dog was able to visit them.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was Requires Improvement (report 5 July 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating and to follow action we had told the provider to take following the last inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Dean Neurological Centre on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good ●

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good ●

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good ●

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement ●

The rating of well-led had improved. The leadership, governance and culture promoted the delivery of high-quality, person-centred care. Some time was needed for newly introduced systems to become part of day to day working.

Details are in our well-Led findings below.

The Dean Neurological Centre

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was carried out by two inspectors, an assistant inspector, an inspection manager, a pharmacy inspector, a Specialist Advisor (SPA) in neurology nursing and case management 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. In this case a person who looks after someone with complex care and communication needs.

Service and service type

The Dean 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received since the last inspection. This included information from the

provider about improvements they had made to the service and notifications about events or incidents which involve people which they must inform us about. We sought and received feedback from commissioners of care and professionals who visited or worked with The Dean. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with five people who used the service and one relative about their experience of the care provided. 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 two managers, employed by the provider, who were working at the home on an interim basis. We spoke with the registered manager and two newly appointed managers; the new home manager and Matron. We spoke with the clinical trainer, head of hotel services manager, the housekeeping lead and maintenance manager. We spoke with 11 care staff, day and night clinical leads and two registered nurses. We spoke with members of the therapy team and the lead therapist. We spoke with an activities co-ordinator.

We reviewed a range of paper and electronic records associated with people's care and treatment. These included seven people's care files.

We also reviewed a range of records related to the management and quality monitoring of the service. These included four staff recruitment files and 15 recent staff supervision records. We reviewed staff competency records and the services main training record. We reviewed a selection of audits, including clinical governance audits, all complaints records and an electronic risk data base recording all accidents and incidents. We reviewed the provider's medicine policy.

We attended one staff handover meeting and one review round completed by therapist.

The Nominated Individual was present at the inspection feedback. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to put systems in place to ensure people always received safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People's health risks were assessed and effectively reduced. This included potential risks such as choking, aspiration (food entering the windpipe) and the dislodging of people's food and tracheostomy tubes during personal care.
- Staff understood where people required support to reduce the risk of avoidable harm. Care plans contained information for staff to follow on how to keep people safe. This included risks associated with diabetes and epilepsy.
- Heads of departments met daily and reviewed any safety concerns; existing risk levels which may have altered and any newly identified risks. Subsequent changes to the management of these risks was then effectively communicated to the staff.
- Some senior staff held lead roles in areas of practice such as safe moving and handling and tracheostomy care and advised staff on how to manage potential risks in these areas.
- Environmental risks were identified, and action taken to reduce these. This included the use of specialised equipment such as hoists and wheelchairs.
- Staff attended handover meetings when they came on duty where information about people's care and risks was handed over by staff going off duty. One member of staff said, "Information around people's changes are shared in handover. I think this works well." Changes in care were also flagged up in the care office for staffs' easy reference. We saw changes to one person's moving and handling instructions and the need to disconnect one person's feed tube before repositioning them had been flagged up.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. There were systems and processes in place to protect people from the risk of abuse. Staff worked with other agencies and professionals to safeguard people.
- Staff had a good understanding of the potential symptoms of abuse and how to report concerns they may have. They were confident that any issues raised about this would be managed quickly and appropriately by their managers. A member of staff told us, "I have had safeguarding training, it covered all aspects of safeguarding. There is also guidance for staff in the office."

- There was visible safeguarding information throughout the home for people, relatives and staff on how to report concerns.

Using medicines safely

- People told us they were happy with the way their medicines were managed and administered.
- There had been improvements to the management of medicines. The medicines policy had been updated to reflect how medicines should be managed in this service. There was improved guidance for staff on the use of medicines prescribed to be taken 'as required' and on how to manage specific health conditions for which medicines had been prescribed, such as, diabetes and epilepsy.
- Staff who administered medicines had their knowledge and competency checked to ensure this remained safe and up to date.
- A pharmacist had not always been consulted (as recommended in the provider's medicines policy) on the best way to administer medicines covertly (medicines administered without the person's knowledge). This was rectified during the inspection.

Staffing and recruitment

- There were enough staff with the right skills and experience to meet people's needs. Staffing numbers and skills were monitored by managers to ensure these remained balanced. Staff on day duty and night duty told us they felt well supported.
- Appropriate staff recruitment checks were completed before staff worked with people. This process helped the provider make safer recruitment decisions, so people were protected from those who may be unsuitable to care for them.

Preventing and controlling infection

- People were protected from the avoidable spread of infection. All staff received infection control training and staff practices, such as hand-washing, were monitored. Findings from the infection control audit were shared with the lead housekeeper so a team approach was taken regarding any necessary actions.
- The home was cleaned by staff who followed set cleaning schedules. The provider followed internationally recognised standards and provided staff with equipment and cleaning products which helped to reduce the potential spread of harmful germs.
- Care staff reduced the risk of cross contamination between people by wearing disposable gloves and aprons when delivering personal care, when helping them with their food and when completing clinical tasks such as wound care.
- Soiled laundry was segregated from other laundry and washed on a temperature which killed harmful bacteria.
- Staff were vigilant in their observations for signs and symptoms of potential infection in people. One member of staff said, "We are always looking for the early signs of Sepsis." We reviewed the actions taken by staff when they had identified early signs of infection in one person's surgical wound site. This was reported quickly to a GP and action taken to reduce the risk of a wider infection such as Sepsis.

Learning lessons when things go wrong

- Details of accidents and incidents were recorded and the circumstances of these analysed for trends and patterns which could be addressed to avoid re-occurrence.
- The same process was carried out with complaints and areas of dissatisfaction received so that learning could come from these and necessary improvements made to the service.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

During this inspection we saw care was delivered in line with best practice, guidance for staff had improved and the delivery of people's care was monitored closely. This had resulted in better outcomes for people.

- People were generally happy with their care. A relative told us they were happy with their relative's care. Feedback from commissioners of care was positive with some specifically describing improvements in people's health and abilities.
- People's needs were assessed before they moved into the home. The decision to admit was made on a multi-disciplinary basis (meaning professionals from different areas of specialism) were involved in the process. The process also included the person where possible or their representative. Due to the complexities of people's needs managers and the lead therapist told us the process had to be robust to be sure the staff and the The Dean's support systems could meet the person's needs.
- Staff described a "wholesale change" in the way they now worked. One member of staff said, "It's more joined up working." The physical divide between the care team and the therapy department had been removed. Staff from both teams worked together in supporting people's needs. This had helped to improve standards of practice and increased the time people spent with therapists. Joint working was seen in the completion of people's muscle stretches, delivery of group upper and lower limb stretching sessions, fitting of people's splints and support given to people at mealtimes.
- Training and support for staff had improved and safe care and treatment was now delivered, in line with best practice guidance. Additional training in the care of feeding tubes inserted through the abdomen (percutaneous endoscopic gastrostomy - PEG) had been provided and several more staff had been trained and assessed as competent in tracheostomy care. Therapy staff had provided support and guidance to day and night staff in the use of new and complex equipment.
- Clinically competent staff monitored the delivery of people's care. A leading specialist in tracheostomy care continued to visit the home. They reviewed people's treatment plans, advised on any necessary changes to these and provided more in-depth training to staff in this area of care. This professional confirmed there were processes in place, at The Dean, to ensure people with tracheostomies received safe care and treatment.
- Other healthcare professionals confirmed staff appropriately reported concerns to them and they could now find the information they needed to make their treatment decisions and recommendations.
- People were involved in regular reviews of their care and therapy. One member of staff told us these reviews were now more focused on the person's choices and preferences. We observed this when we joined

one of the review rounds.

Staff support: induction, training, skills and experience

- Support and training for staff had improved. One person said, "The care staff, day to day, are mostly very good, the ones I've met are trained." A member of staff said, "I am happy with the amount of training. There are options for extra training; national vocational qualifications and higher levels." We spoke with three staff who told us they had recently been supported and funded (by the provider) to study for higher qualifications. Further on line and face to face training was planned which included palliative and end of life care.
- A trainer was now employed and based in the home. They said, "We have gone back to basics with all training. If staff tell me they have completed the training but can't prove this by producing a certificate, or, there is no record of proof here, then staff are completing trainings again." In the meantime, staffs' competencies in areas of practice were assessed. If found not to be competent they did not carry out care tasks in that area until trained and assessed as competent. Additional training had been provided in conflict resolution and challenging behaviour, wound and continence care.
- Some care staff were qualified to train and support other staff, in areas such as safe moving and handling and tracheostomy care. These were staff who worked alongside other staff so could also monitor staff practice daily.
- Nurses and therapists (Physiotherapists, Occupational Therapists and Speech and Language Therapists) were supported to complete training and continuing professional development to be able to remain registered with their professional bodies; for nurses the Nursing and Midwifery Council (NMC). A nurse told us, "We use our training to ensure we are kept up to date. If you ask for training the service is very good at finding training for us to do."
- There were arrangements in place for all staff to be provided with professional supervision and performance appraisal. Agency staff were supported to become aware of the provider's policies and procedures and general expectations before they started work in the home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff liaised effectively with the emergency services when needed. Professionals working in the local acute hospital told us there was improved communication and sharing of information when people transferred into their care.
- Staff worked with NHS Rapid Response teams to deliver some treatments to people, in the home, to avoid hospital admissions where it was at all possible to do this safely.
- The provider had arrangements in place to support the regular review of people's health needs. This included visits by a regular GP who understood people's complex needs. One person said, "The GP visits regularly, and there is chiropody and dental support." Another person said, "GP access has improved."
- Regular multi-disciplinary meetings were attended by senior staff, GPs, Specialist Consultants and other healthcare professionals. One member of staff told us these had improved, both in the information now being brought to these and in how actions from these were now followed up.
- People received support with their oral hygiene. One member of staff was taking a lead in implementing new national practice guidance in relation to this. Designated oral assessments and care plans were to be implemented and if not already registered with a dental practice, this would be arranged for people on their admission to the home.

Adapting service, design, decoration to meet people's needs

- The home had a spacious and open plan layout making it easy for people in specialised wheelchairs and beds to move from their bedrooms to communal areas where they could socialise. There were tea and

coffee making facilities in these areas for family, friends and other visitors helping to make visits to people more relaxed.

- The service had adapted bathrooms where specialist equipment had been fitted to help people with complex physical needs shower and bathe. Some bedrooms were fitted with electronic ceiling hoist tracks to assist in the safe moving of people.
- People were able to personalise their bedrooms. We saw rooms had been individualised to people's tastes and contained personal items. A wall in one bedroom had been painted with blackboard paint, so the person could draw on it with chalk. The home manager told us they asked each person their colour preference before their rooms were redecorated. Other areas of the home were being redecorated to both update it and make it more like a home to people.
- People had easy access to a large decking area with a range of tables, chairs and benches where people could sit and socialise.
- Staff had worked hard to ensure that (where relevant) people had access to environmental controls. Environmental controls are devices that allow people with mobility or dexterity impairments to operate electronic devices, including televisions, computers, lights and other appliances using their voice or a communication aid.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff were updated with specific information about people's dietary and eating and drinking needs. A person said, "They're very good at helping me eat." Staff knew people's likes and dislikes.
- People's essential dietary information, for newer staff or agency staff, was available on a placemat. This included easy to follow information about specific people's textured food and thickened drink needs, in line with best practice guidance.
- Care staff worked with healthcare professionals and the home's therapists to ensure people's specific nutritional needs were fully assessed and met. This included the assessment of potential risks such as choking and aspirating (food entering the windpipe) when eating or drinking. We observed some people receiving intensive support at mealtimes to support their mealtime needs.
- We observed most people to be enjoying their meal-time experience which staff had worked hard to improve. A person said, "Since the last CQC (inspection) the food has improved enormously, the method of choice, and quality improved. There's an evening menu now, a major success."
- Staff supported everyone whose physical or cognitive abilities did not allow them to access food and drink independently throughout the day. For some people this was through a tube located in their abdomen. We saw people's weights remained under review with the appropriate advice and guidance sought should a concern be identified.

Ensuring consent to care and treatment in line with law and guidance

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.

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 had the appropriate legal authority and were being met.

- Staff had received training in the MCA and DoLS and understood their responsibilities in these areas. They asked for people's consent before providing any care or support. A member of staff told us, "We are aware that residents are able to make unwise decisions and take that into consideration whilst always maintaining their safety."
- Where people were unable to make decisions for themselves their care records included a mental capacity assessment and/or best interests' decision made on their behalf by appropriate persons; healthcare professionals, people's representatives and advocates. Decisions were made by involving the person as much as possible.
- We reviewed the service's records in relation to DoLS and were shown how the service kept information about these under review and current. We saw that where appropriate, DoLS had been applied for, any conditions relating to DoLS had been met.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care

Ensuring people are well treated and supported; respecting equality and diversity

- People at The Dean lived with life changing and ongoing complex needs which the staff team demonstrated an enormous amount of respect for.
- We observed staff showing warmth and encouragement towards people when they were upset or feeling unwell. Staff used gentle banter and humour in their interactions with people, we saw this was familiar to people and often reciprocated. People were spoke with in a respectful way. This told us healthy and therapeutic relationships had been built between staff and people.
- The provider's policies and how the home was managed continued to ensure people were treated equally and according to their protected characteristics; age, disability, race, religion or belief, sex, sexual orientation or chosen relationships with people.
- To help maintain continuity of personalised care when people, who were not able to communicate personal preferences, were transferred into the care of other professionals (such as a hospital admission), a record had been introduced which gave personalised information about the person. This included for example, what may cause worry or upset to them and what helped to relax them. A healthcare professional who received people into their care, when they were poorly, told us this had been a helpful improvement.
- We found improvements had taken place in the care of people who became distressed and anxious, which resulted in behaviours which could be perceived as challenging. Staff had received further training in supporting people's behaviours and in how to better identify and remove triggers, which had previously led to distressed and challenging behaviour.

Supporting people to express their views and be involved in making decisions about their care

- People had opportunities to express their views and where able to do so, were involved in making decisions about their care and treatment. We saw people making daily choices during the inspection and their care records demonstrated that they had been involved in decisions made about their care.
- People's goals and aspirations were listened to when planning their therapy. This was done informally when working daily with people and more formally when completing planned reviews with people. One therapist said, "What we are working on has to involve the person." They went onto explain that the therapy plan had to include choices and decisions made by the person for it to be successful. In one person's case it had taken staff many months of work to help the person identify what their true goal was and how to tailor the funded therapy time to help achieve this.
- There was evidence to show that staff worked with people's representatives, relatives and advocates to

support people to make as many independent choices and decisions as possible.

Respecting and promoting people's privacy, dignity and independence.

- People's personal care was delivered in private and records about their care and treatment kept secure. Staff acted, when required, to ensure people's privacy and dignity was upheld, for example, at visiting times when there were risks that it may not be. People's correspondence (post) was kept private and given to them or their representative. A member of staff said to one person, "I have left a letter for you in your bedroom."
- People's bedrooms were recognised as being people's private spaces and respected as such. We spoke with one of the housekeeping staff who spoke explained how they cleaned people's bedrooms and worked around their private belongings. Where needed items were moved to clean and then put back where they were found.
- People's individual preferences for how their privacy, dignity and independence was maintained, when they required twenty-four-hour, one to one monitoring of their tracheostomy, were discussed with them or met according to best interests decisions made about this. In some cases, we therefore saw staff located just outside of people's bedroom doors, completing their monitoring from there and only entering when they needed to carry out a necessary task.
- People's wishes and aspirations to be as independent as possible were respected and supported by the staff. Changes to how the therapy department worked had improved people's access to the support they needed to maintain skills and abilities which would support varying degrees of independence. One person said, "The physio lets me use the [exercise] bike for 10 minutes a day." We learnt during the inspection that a lot of work was being done by the lead therapist to get more flexibility in how people's therapies were funded. This was so funded therapy time could be more tailored to people's specific goals and aspiration and the focus could be on the areas that people wanted to be more independent in.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to make enough improvement to people's care records and ensure these were kept up to date so staff and visiting professionals could find the guidance and information they required. This was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- People's care records, which included, care plans, were more organised. Care plans gave staff updated guidance on how to meet people's needs and staff confirmed finding this information was much easier. Professionals confirmed they could find the information they required when they visited. Managers told us further improvements were planned to how information about people's care and health was stored. This work was to start following this inspection.
- Since the last inspection the content of people's care plans had been reviewed and where needed care plans had been re-written or more detailed guidance added to them for staff reference. New care monitoring records had been introduced and this had been the managers' prime focus, to get these in place so the service could demonstrate that people's risks were monitored, and the care delivered to people was recorded accurately.
- The care plans we reviewed gave staff clear guidance on areas such as catheter care, pressure ulcer reduction care, diabetes and epilepsy. When we cross referenced these with the care monitoring and delivery records, we could see people's risks and needs were being met as planned.
- People's care plans included details about their preferred daily routines, supporting a person-centred approach to care. Preferences around, sleeping, waking up, washing, eating and social activities were all recorded. It was one person's preference to have a late evening shower, so their care plan and care routine had been altered to accommodate this. A member of staff said, "We ask people what they want and refer to their care plans. We have a lady who has requested only females to support her care needs." We were able to evidence that this preference was respected and met.
- People told us their care plans were written by the staff, but they had opportunities to discuss these, question the content and contribute to the planning of their care. One person said, "Absolutely I participate in my care plan." One relative involved in the planning of their relative's care said, "Staff will come to me and ask me what I think. I get on well with all the staff here."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There was a strong focus on Speech and Language Therapy supported by therapy assistants, the care team and the activities staff. Assistive technologies were used creatively, and innovative technologies were developed with people to enhance their communication and independent expression of feelings, views and opinions. Staff worked hard to make sure, that where it was possible, people had access to the support they needed to communicate and lead as full a life as possible.
- Every person had their communication needs assessed and provided for. People with visual impairment and hearing loss had their needs met. Staff ensured that devices and equipment needed by people to help them remain included were fitted properly.
- We met a range of people who had their own computer tablets or communication devices. We witnessed how people engaged with staff and used these technologies to seek support. One person we met asked a speech therapist for assistance by coughing and then using their electronic device.
- The service supported people to use a range of other communication devices. Some people used a virtual assistant to put on music without the need to physically do this themselves, thus enabling them to feel a sense of freedom and independence. People were supported to communicate with family and friends by using applications which supported video chat and voice calls between computers and mobile telephones.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to enjoy a range of activities either on a one to one basis or in groups. Activities were adapted to suit people's range of abilities as staff wanted everyone who could to be included. Activities such as arts and crafts, quizzes and watching documentaries were enjoyed by people. The activities co-ordinator said, "People tell us what to do really. They decide what they like and want to happen, and we make it happen."
- A recent visit by an Llama was enjoyed by several people who were able to see and stroke it in the communal rooms. Those confined to bed had also been involved as the Llama had been taken to people's bedrooms. There were photographs on display that clearly showed this had meant a lot to those nursed in bed. One person's care record recorded their choice not to see the Llama, so this had been respected.
- People's spiritual needs and preferences were discussed with them and people could attend religious services, held monthly at The Dean, if they chose to.
- A minibus had recently been purchased to enable more people to enjoy the wider community. Additional training for staff in the management of people's tracheostomies and more volunteers, from students on university placements, had increased people's opportunities to go out.
- People and staff had recently planned a fundraising event to support staff colleagues from the providers network in Australia, who had been affected by the recent forest fires. One person told us how a 'table-top sale' had been planned to raise money. They told us they were proud to be able to help raise some money and provide aid to those in need.

Improving care quality in response to complaints or concerns

- The number of complaints received had reduced following the last inspection. The service had received three complaints, and these were investigated in line with the provider's complaints policy.
- Several systems were available for people to raise their concerns and we found these had been effective.
- Lessons were learnt from complaints. As a result, for example improvements had been made to respiratory equipment checks and the service put systems in place to ensure when people show distressed behaviour

this is shared with relevant health professionals in a timely manner.

End of life care and support

- People's palliative care was supported and reviewed by regular input from a consultant who specialised in palliative and end of life care and treatment. Support was also provided by this consultant at the end of people's lives so they might have a dignified and comfortable death. A nurse told us, "We work with a palliative care consultant who has written some protocols (formal, agreed guidance) for some of our residents in relation to end of life needs."
- People's end of life care wishes, and preferences had been discussed with them or with their representative and this detail recorded in their care plans. Preferences related to culture and religion were also recorded for staff guidance.
- Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, were located at the front of people's care files and were easy to locate in the event of an emergency.
- People's wishes regarding further medical intervention, in the event of an emergency, when their health may have already deteriorated, had been discussed with them and recorded.
- The service had received compliments from people's relatives in respect of end of life care. One card received from a relative stated, "Once again, thank you for the care and compassion you showed [name of person] in his last few days."

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to Requires Improvement. The day to day service management was new and time was needed for the new managers to fully understand the service. Leaders and the culture they created had started to support the delivery of high-quality, person-centred care; time was needed for all the planned improvement work to be completed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to effectively operate their systems to monitor and mitigate risks relating to the health, safety and welfare of people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- The provider had shared with us their improvement plan and monthly progress reports following our previous inspection. They had appointed an interim management team to lead on the improvements.
- Throughout our inspection we received positive feedback from people, relatives, staff, commissioners, health and social care professionals about the improvements that had been made. A relative said, "The problem the service did have, have been put right. It's much better."
- The service had developed a comprehensive system of assurance to ensure risks and performance issues were effectively reviewed, escalated and addressed. The new governance processes provided effective oversight of people's care in relation to for example. diabetes, skin integrity, eating care, catheter care, respiratory care and safety incidents
- When incidents had occurred, or audits had identified shortfalls this information was used to strengthen staff practice and assurance processes and identified risks to people's safety. As a result, staff had been retrained in many areas and for example, the type of feeding tubes being used were being reviewed.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff were given opportunities to lead on areas such as oral care to develop and share current best practice.
- A newly appointed Service Director had applied to the CQC to become the new registered manager of the service. A new Matron was also now in post and both were continuing with the improvements made so far and ensuring these were embedded in staff practice. Staff and people told us the two new managers were visible and approachable in the service for people and staff. They supported staff, and each other and told us they were supported by the provider and senior managers to work as a cohesive leadership team to deliver the vision and strategy of the service.

- We found the new managers were becoming familiar with the risks in the service and what improvements still needed to be made. The new home manager had put systems in place to monitor progress. Time was needed for the new managers to fully understand the service and to ensure all the planned improvements were completed. For this reason, we have rated this key question requires improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us the service was well managed. The culture had become increasingly empowering, and people were fully involved in achieving their potential and there was a range of meaningful activities and therapies.
- Staff felt respected, support and valued by their team and wider management. Morale was reported to be much improved. Staff felt proud to work in the service and spoke with passion about people's achievements. A member of staff said, "Our line manager is very supportive. The management are open to listening to our views." Progress had been made on recruiting and retaining staff.
- Engagement with people and relatives was meaningful and extensive. Regular Residents Forums and surveys took place and we found activities had improved following people's feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider understood their responsibilities.

Continuous learning and improving care; Working in partnership with others

- The provider had shared the previous inspection findings with people and staff and we found everyone felt involved in making the service better; including night staff.
- Following our previous inspection, the provider had reviewed their quality monitoring systems to ensure they would monitor the key aspects of a neurological rehabilitation nursing home.
- The provider was developing a service model to better meet the needs of people with neurological needs and was meeting with commissioners and other stakeholders to inform this development.