Four Seasons Beechcare

The Peter Gidney Neurodisability Centre

Inspection report

Darenth Road South
Dartford
Kent
DA2 7QT
Tel: 01322628077

Date of inspection visit: 29 and 30 December 2014
Date of publication: 18/03/2015

Ratings

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

Overall summary

The inspection was carried out on 15 and 16 December 2014 by two inspectors, a specialist advisor nurse, and an expert by experience. It was an unannounced inspection. The service provides care and accommodation for up to 26 disabled adults with acquired brain injury or other complex conditions. There were 22 people living in the service at the time of our inspection. All the people who lived in the service had varied communication needs. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff while some people were more independent.

At the last inspection on June 2014, we found the provider was in breach of Regulations 9, 10, 12 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to make improvements about the planning and delivery of

Summary of findings

people's care and treatment; infection control management; people's personal records; records relevant to the management of the service. We received an action plan that said that improvements would be completed by 30 September 2104. During this inspection, we found that the actions that had been required have been completed but improvements were needed to embed these into practice. We also made two new recommendations related to meals and activities.

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. However, the provider had notified us that the registered manager had been absent from their post since 14 October 2014 and that the interim management of the service was carried out by an acting manager with the support of a senior centre manager.

Meals were prepared off site in a neighbouring care home's kitchen and transported to the service. Menus were repetitive and people were not satisfied with the food that was provided.

People were not involved in activities that were meaningful for them or frequent enough to meet their needs.

The environment was safe and appropriate for the people living there. Measures were in place to ensure that the home was secure. The environment was clean and well maintained. A member of staff was the designated lead in infection control and carried our regular audits to check that people were protected appropriately from acquired infection.

The service held a policy on the safeguarding of adults that was current and included clear procedures for staff to follow. However, not all the staff had completed their training in the safeguarding of adults and in the principles of the Mental Capacity Act 2005 (MCA). They were scheduled to attend this training within the next two months. The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We found the management to be meeting the requirements of the DoLS.

There were sufficient staff on duty. Staff had time to spend supporting people in a way that respected their individual needs. The acting manager reviewed people's care needs whenever these changed to determine the staffing levels needed and increased staffing levels accordingly.

The service followed safe recruitment procedures and staff were subject to disciplinary procedures when appropriate.

The nursing staff who administered medicines followed the correct procedures for safe administration. The maintenance of records relevant to the administration of medicines was being monitored.

The service had an organisational contingency plan in case of emergencies. People had individual emergency evacuation plans. The fire protection equipment was regularly serviced and maintained.

Staff told us the communication between staff and management had "greatly improved". Staff were made aware of people's changing needs at handover and during meetings. Staff were aware of people's individual communication needs. Staff provided positive support that promoted people's independence and protected their rights.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect. People who were able to talk with us told us they were satisfied with the way staff cared for them.

People's health was promoted and protected, staff made sure people were referred to health care professionals and that visits took place as needed. People's individual assessments and care plans were reviewed monthly with their participation or their representatives' involvement. These were updated to reflect people's changing needs and preferences. The delivery of care that we saw being provided was consistent with people's requirements, as planned in their care plans.

People's feedback was sought and they were involved in the planning of the delivery of their care. Yearly satisfaction questionnaires were sent to people and their relatives or representatives to collect their feedback. All feedback was analysed to identify improvements that needed to be made and action was taken to put these into practice.

Summary of findings

There was an open and positive culture at the service which focussed on people. The acting manager had been in post only seven weeks and had implemented several positive changes in the service. The staff confirmed the acting manager was supportive and understanding of the demands of their role.

There was a system of quality assurance in place to monitor the overall quality of the service, identify the needs for improvements and ensure these were carried out. The senior centre manager visited the service every two weeks to support the acting manager, complete quality assurance audits and monitor improvements. The acting manager carried out daily, weekly and monthly audits to assess the quality of the service and ensure all documentation was accurate.

We recommend that the registered provider seeks and follows guidance to ensure people receive a diet that suits their needs, requirements and preferences regarding, quality, variety and quantity of food.

We recommend the registered provider seeks and follows guidance on providing activities that are meeting people's daily social needs and preferences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Appropriate measures were in place to ensure that the home was secure.

A system had been used to make sure enough staff were employed to safely meet people's needs. Safe recruitment practices were followed when employing new staff.

Medicines were stored and administered safely.

The environment was clean and well maintained and people were protected against the risk of infections. There was a plan for emergencies in place.

Good

Is the service effective?
The service was not consistently effective.

The food that was provided did not meet people's needs or preferences and people were dissatisfied with the food.

There were suitable arrangements in place to ensure that staff had been or would be trained appropriately for their roles.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People received support that promoted their independence. Staff communicated effectively with people.

There were arrangements in place to support people to remain well.

Requires Improvement

Is the service caring?
The service was caring.

Staff were kind and respectful to people. Staff promoted people's rights to privacy and dignity.

Clear information about the service and explanations relevant to daily routines were provided to people and visitors.

People were involved in the planning of their care.

The staff promoted people's independence and encouraged them to do as much as possible for themselves.

Good

Is the service responsive?
The service was not consistently responsive.

The provision of activities did not meet people's wishes, expectations or needs.

Requires Improvement

Summary of findings

People's records of care and support were personalised to reflect people's wishes and what was important to them.

Staff responded to people and delivered care that was consistent with the assessment and planning of their needs.

The service took account and acted on people's complaints, comments and suggestions.

Is the service well-led?

Good 

The service was well-led.

There was an open and positive culture which focussed on people.

Staff found the acting manager approachable and had confidence in the acting manager's support and advice.

There was a system of quality assurance in place to monitor the overall quality of the service, to identify the need for improvement and take the necessary actions.

The Peter Gidney Neurodisability Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was carried out on 29 and 30 December 2014. It was an unannounced inspection. The inspection team included two inspectors, one specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of neurological disorders.

Before our inspection we looked at records that were sent to us by the registered manager or local authority social services department to inform us of any significant changes and events. We reviewed our previous inspection reports. We consulted NHS commissioners and the local authority safeguarding team and obtained their feedback about their experience of the service.

We looked at records in the home that included six people's personal records and care plans, risk assessments, six staff files, staff rotas and training records, ten medicines administration records (MAR), audits, and the service's policies and procedures. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these plans.

There were 22 people living in the service at the time of our inspection. All the people who lived in the service had varied communication needs. Some people were able to express themselves verbally; others used body language to communicate their needs. As not all the people that lived in the service were able to communicate verbally with us, we used the Short Observational Framework for Inspection (SOFI), to capture the experiences of people who may not be able to express this for themselves. SOFI is a way of observing care to help us understand their experience. Using the SOFI tool helps to raise questions about care practice that is then followed up by checking other sources of evidence.

We spoke with nine people and five of their relatives. We spoke with the acting manager, the senior centre manager, six members of care and nursing staff and the activities co-ordinator. We spoke with a specialist Multiple Sclerosis nurse, a local authority case manager who oversaw a person's care in the service, two members of a local hospice palliative team and one physiotherapist who visited the service regularly.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. One person told us, "I feel in security here" and, "It is safe enough, if we have a problem staff come to our rescue". This showed that people felt confident that staff would ensure their safety. A relative said, “The place feels safe, our family is confident that people are cared for and protected here”.

We found that the service was safe and appropriate measures were in place to ensure that the service was secure. Visitors entering the premises signed in and out and documented the reason for their visit. This ensured that only people with a legitimate reason were able to enter the premises.

The staff had access to, and knew about the policy on the safeguarding of adults which included clear procedures for staff to follow. The policy had been reviewed and updated in November 2014 so it remained current.
Staff were trained or were scheduled to attend refresher courses in safeguarding adults. The staff we spoke with had an appropriate knowledge of how to identify abuse and respond to protect people. They told us they would report any concerns to the acting manager as soon as they arose. The staff were aware of the service's policy on whistle blowing. One member of staff told us, "It is our responsibility to alert the manager straight away if we notice bad practice". Appropriate referrals had been made to the local authority safeguarding team when needed.

Risk assessments were centred on the needs of the individual. They included details on the severity, frequency and rating of the risk that was identified. Action staff needed to take to reduce the risks had been identified and reviewed regularly to ensure they remained sufficient. The staff were aware of the actions needed to keep people safe and they followed the guidance.

Accidents and incidents were recorded by staff and their level of severity was assessed. They were monitored daily by the acting manager to ensure hazards were identified and reduced. We followed the pathway of three incidents that included a fall, an altercation between people and a medicines error. Details of the events, of action taken and of the completed documents were entered in a computerised system and sent to the senior centre manager who checked whether any common triggers could be identified. Remedial action was planned and implemented. This ensured that the risk of re-occurrence was reduced.

There were sufficient staff on duty during the day. In the morning, seven care workers and two nurses were deployed. In the afternoon, there were four care workers and one nurse. On the day of our visit we saw staff had time to spend supporting people in a meaningful way that respected individual needs. The acting manager reviewed the care needs for people whenever their needs changed to determine the staffing levels and increased staffing levels accordingly. For example, an additional care worker had been deployed following an altercation between two people to provide one to one support for a person. There were staff employed for maintaining the premises, administration, catering and domestic duties.

Three people told us that the number of staff deployed during the night was not adequate in meeting their needs. They told us “When I had to use my buzzer at night to get assistance, I had to wait for some time before anyone came” and "Two care workers are not enough at night because some residents need to be turned in bed and toileted so other people have to wait sometimes too long a time at night, but there is enough staff during the day". Two staff and one nurse were on night duty. We discussed people’s views with the acting manager who told us they had assessed people's levels of dependency and that enough staff were on duty at night. They said, "On occasions staff may take longer in responding if they have to go to another person with more urgent needs, although they go and explain this to people. Agency staff are only used as a last resort when permanent staff are unable to cover vacancies and colleagues' unexpected absence and we try to avoid using them at night as much as possible". The staff rotas that we saw confirmed this.

We asked staff if there were sufficient numbers of staff on shift to meet the needs of people who lived at the home. They told us that they sometimes did not have enough staff on shift due to sickness and this limited the time they could spend with people but it did not prevent them giving people the care they needed. The provider was in the process of recruiting more staff and had considered ways of doing so effectively.

The service followed safe recruitment procedures that included the checking of references and the carrying out of

Good

Is the service safe?

disclosure and barring checks for prospective employees before they started work. Records were kept of job interviews and assessments that were carried out to check if potential staff members were suitable for the role they were applying for. Several personnel files showed gaps in employment history and the reason for this had not been documented. We brought this to the attention of the senior centre manager and the acting manager who confirmed to us that an audit of personnel files' documentation was in process. They told us, “We have identified this and are in the process of updating all staff records”.

All staff were subject to a probation period before they became permanent members of staff and to disciplinary procedures if they behaved outside their code of conduct and expected standards of work. The provider had used these procedures when they had been required. This showed they knew how to protect people from unsuitable staff.

Medicines were administered correctly. One person received their medicines with their favourite food by choice. One person told us, "They never forget my meds; they give it to me like clockwork". Another person said, "I have never had any issues with my meds and it is always given to me at night when it should be". One nurse administered medicines to three people who required them through a tube because they were unable due to their medical condition to take them orally. Another nurse administered medicines orally to other people. We observed the nurses helping people to take their lunchtime medicines and checked their knowledge about the medicines they administered. They followed the correct procedures and spoke knowledgeably about the medicines they gave to people.

A pharmacy provider that supplied the medicines to the service had completed an audit on 9th December 2014 and had recommended an improvement to the records. On a number of occasions MAR charts and the recording of room and refrigerator's temperatures were not appropriately maintained. The acting manager was aware of the recommendations and was monitoring the records to ensure they were appropriately completed. A medicines competency assessment had been completed for one nurse and the acting manager had scheduled further medicines competency assessments to take place within the next two weeks for all the nurses. This meant the acting manager had already taken action to ensure the records relating to medicines were improved and completed correctly.

The environment was clean and well maintained. Cleaning schedules were appropriately completed to show that cleaning as well as deep cleaning was carried out regularly. A system was in place to ensure that wheelchairs were regularly cleaned. There were plenty of cleaning products in stock and systems were in place for regularly ordering a new supply. People's laundry was managed appropriately using the correct washing temperatures to prevent infections.

At our last inspection we found that no checks were in place to monitor infection control. During this inspection, we found that a member of staff was the designated lead in infection control and had carried out regular audits to check that people were protected appropriately from acquired infection. The last audit was carried out in November 2014 and included recommendations for improvements that had been implemented. Personal protective equipment (PPE) that included plastic aprons and gloves was readily available. Care and nursing staff used this equipment appropriately when they cared for people’s personal needs. Reminders were displayed within the home reminding staff to wash their hands. Nurses washed their hands before and after administering medicines.

Measures were in place to ensure people were protected in case of fire or other emergencies. Staff had access to a 'grab bag' that included first aid equipment and people's individual emergency evacuation plans. Each bedroom had a call bell alarm system, which enabled people to call a member of staff when they needed assistance. People who were unable to use their call bell were checked regularly by staff to ensure they were comfortable and respond to any requests they may have. These checks followed guidance in people’s care plans and were recorded. All staff were trained in first aid and fire awareness. People's wishes regarding resuscitation were held in their files when applicable. The acting manager was available during out of office hours in case of emergencies.

Requires Improvement

Is the service effective?

Our findings

People commented positively about their care but they were not satisfied with the food they were offered. One person said, “The food is repeated a lot during the week”. Other people did not like the lack of choice, the quality or quantity of food. One person told us, “The staff know what I need well and I can trust them.” One relative said, “The staff communicate well with my family member and they understand each other well". People’s needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs effectively. Staff handover meetings were held twice a day to communicate people's individual needs, to which all care staff attended. Updates concerning people’s welfare were appropriately communicated to ensure continuity of care. A nurse from a palliative care team told us, "They are very good at communicating with us".

The food did not meet people’s expectations, choices or needs. People were not complimentary about the food that was provided. They commented, “The food is so repeatitive", "The food is horrible, they tried a menu for two weeks which was nice but now it is back to being repeated a lot, the alternatives if you don't like the two choices are either a salad or a sandwich and nothing hot", "The portions are too small" and "It's not a bad place apart from the food". One person told us "Food is OK and I get enough, at least there are plenty to drink and snacks available to fall back on in between meals". One person told us they had requested additional fried eggs in the morning but was told the cook was unable to prepare this as they were busy preparing lunch. The presentation of the food was unappealing and people told us it had no taste.

The food was cooked off site due to a lack of a suitable kitchen on the premises. The food was stored and prepared at the neighbouring care home then transported using insulated boxes. The food's temperature was checked at each stage of the process. People were assisted at mealtimes when needed to ensure they ate at a pace that suited their needs. Specific dietary needs for people who had diabetes or for people who needed soft diet were respected. Staff offered a choice of drinks and snacks throughout the day.

People chose each day from a set menu what they preferred for the next day. This ensured the kitchen staff knew of individual requirements but they were not always able to provide for these. When the food was served, people commented, "Oh dear, that is not very exciting" and "Oh no it is crumble again, that was the pudding yesterday". One person chose to eat a meal instead which they had bought in the community and staff heated it for them in a microwave oven in a kitchenette. People had requested yoghurt instead of the dessert and the acting manager had needed to go and buy some.

The cook told us that they had tried to put dishes on the menu that were suitable for both older people in the adjacent home and for the younger residents of the service. They told us, "Due to having to cook in one kitchen for two sites and cater for different ages and appetites, it is not working well".

The acting manager and the senior centre manager told us they were aware of people's dissatisfaction and this was reflected in a food survey that was carried out in November 2014. They told us, "Menus do not reflect people's choice and the overall quality of food is not satisfactory". Following the survey, the provider’s food safety manager had visited the service to identify how this could be remedied. They had reported that food was "Cooked off far too early in the morning", that portion sizes were not adequate for people whose appetite differed from older people who lived in the adjacent care home. This meant that the provider had recognised the need to improve the food quality, quantity and service and had started to plan to take action but people remained very dissatisfied. We have made a recommendation related to this.

Each person’s needs had been assessed by the acting manager before they came into the service and the staff were made aware of the assessments by the acting manager. This ensured that the staff were knowledgeable about people’s particular needs before they came to stay.

A key worker system was in place. Key workers are staff who have special responsibility to ensure effective care if delivered to a named person. The acting manager told us, "I am in the process of re-allocating key workers and making sure each person is matched with the most appropriate member of staff". People usually knew who their key workers were and that they could ask them as well as other staff for anything they needed or wanted.

Staff communicated effectively with people using methods which suited each person. This included pictorial aids, effective eye contact and effective use of body language.

Requires Improvement

Is the service effective?

For example one person communicated by holding their thumbs in different positions and all staff were aware of this particular communication need. This was outlined in their communication care plan.

Positive support that promoted people's independence was provided. Two people received additional support and rehabilitation treatment from a physiotherapist and occupational therapist before they were assessed as able to return home. This support meant that people were helped to remain independent or to gain new skills to enhance their independence.

Staff had received induction training and had needed to demonstrate their competence to senior staff before they had been allowed to work on their own. The staff were scheduled to complete their training or refresher courses in the safeguarding of adults and in the principles of the Mental Capacity Act 2005 (MCA) within the next two months. Staff had the opportunity to receive further training specific to the needs of the people they supported. For example they were trained in end of life care and conflict resolution. Staff had attended training courses on neurological deficit and spasms and challenging behaviour. One member of staff told us, "This was really interesting and we learned a lot that we could apply in practice". One nurse and a senior care worker had received advanced training in end of life care at a local hospice and the acting manager had requested similar training for all staff. Additional guidance was available in the staff room in the form of a poster outlining 'hot topics' including medicine errors, preventing pressure ulcers and patient involvement. This showed that staff were given further information about issues that impacted on their practice and the care of people.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the acting manager and they demonstrated a good understanding of the impact on people. They told us, "Our residents must not be deprived of their liberty unless it has been authorised by the local authority. The action taken must always be the least restrictive option and in their best interest". The acting manager confirmed that no restraint was used at the time of our inspection. One application had been made to the local authority for a decision to restrict a person in their best interests and this had been done using the correct procedures. Not all the staff had been trained to fully understand the implications of the MCA and the DoLS but they knew when to report any concerns and guidance was available to them. Training had been arranged within the next two months.

An independent mental health advocate that specialised in cerebral palsy had been appointed to represent one person's point of view. The acting manager had assessed 18 people's mental capacity when they used bed rails to reduce the risk of them falling from their beds. The acting manager had scheduled meetings with some of the people's representatives when applicable, to discuss whether this restrictive option was in their best interest. This meant the acting manager had applied the principles of the MCA 2005 and DoLS in practice to protect people's rights.

Consent was sought before staff provided assistance. One person told us, "The staff always check if it is OK with me and if it is not they come back later to see if I have changed my mind". Consent for care and treatment and for the use of their photographs was obtained from either people or their legal representatives at each review of their care plans.

People were supported and helped to maintain good health. There were arrangements in place to manage the care of people who became unwell. Food and fluid intake was recorded and monitored for people who were at risk of malnutrition or dehydration. People were weighed monthly and were referred to a dietician or GP when their appetite or weights had significantly increased or declined. Prompt referrals were made to relevant health services when people's needs changed. People had been referred to nurse specialists in palliative care and skin integrity, speech and language therapists, occupational therapists and physiotherapists appropriately.

We recommend that the service seeks guidance and implements this in relation to meeting the nutritional needs and wishes of the people they care for.

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. One person told us, “The staff are very nice people”. Two relatives said, “The care is good and” and, “The staff are always pleasant, always welcoming”.

There was frequent friendly engagement between people and staff and staff responded positively and warmly to people. When one person had to wait for support from a staff member they were asked if this was acceptable to them. We observed a staff member playing a game on an I-pad with two people. They were encouraging and supportive and the people clearly enjoyed the activity. A member of staff told us staff were at their busiest in the mornings but looked forward to afternoons when they had time to spend chatting to people. A member of staff was singing softly to a person who remained in bed while carrying out their task and the person was smiling.

Staff promoted people's rights to privacy and dignity. They knocked on people's bedrooms doors or on the doorframes when people had chosen to leave doors open to announce themselves before they went in. Personal care was provided in a private and respectful manner. When administering medicines to people who had a tube surgically inserted through their abdomen, the nurses respected people's privacy and dignity by shutting their bedroom door. People chose what to wear and staff assisted them to dress in a way that met their own preference and styles. Staff were aware of people’s history, preferences and individual needs and these were recorded in their care plans. A member of staff told us how they recalled stories about travelling to a person who had enjoyed travelling before their acquired brain injury. Recordings of ‘rock and roll’ music were played to a person who used to play in a band.

Clear information was provided to people and visitors. The service provided a comprehensive brochure for people and visitors that described the facilities and the services. The new brochure that would be put in place soon contained pictorial information for people who may have communication difficulties. It included clear information about how to make a complaint according to the service's complaint policy. One relative told us, “We are aware of the complaint policy and are kept well informed”.

Staff explained to people each step they were about to take when they assisted them to move with appropriate equipment and when they repositioned them in bed. This ensured people understood what to expect and reduced their levels of anxiety.

People were involved in the planning of their care. For example, a person had requested physiotherapy and this was included in their care plan and implemented. When a person expressed the wish to drink alcohol in their room in moderation this was included in the planning of their care. Care plans had been reviewed with people's participation or with their representatives' involvement when possible.

The staff promoted independence and encouraged people to do as much as possible for themselves. For example, a person who was to return to their home was encouraged to practise daily tasks and was assisted by an occupational therapist. A person received physiotherapy to enable them to regain confidence and walk independently. Another person went out of the service unaccompanied into the gardens if they wished and told us, "In the summer I like to walk to the pub down the road and have a beer”.

People who required end of life care were referred to a local palliative specialist team. The specialist nurses worked with the staff to ensure people remained comfortable. Pain management was monitored daily to ensure people were as pain-free as possible. People’s end of life wishes were recorded in their care plans when they came into the service. One person had expressed the wish to remain in the home and not be hospitalised and their wish had been respected. Counselling for staff and some people had been scheduled by the acting manager following the death of a young person in the service. The staff told us, "Everyone has been deeply affected and it is good to know that this is acknowledged".

Requires Improvement

Is the service responsive?

Our findings

People were dissatisfied with the lack of frequent meaningful activities to suit their preferences and needs. People told us, “People here have been bored” and, “No one is interested in hangman and bingo”. People’s individual assessments and care plans were reviewed with their participation or their representatives’ involvement. One person’s relative told us, “We have been asked to take part in the review of our family member's care and we could not so we asked to take part in the next review”.

The lack of activities available did not meet people’s expectations or wishes. A person told us, "There are not enough trips out". People stayed in their room or in the lounge watching television or listening to the radio. One person played 'scrabble' on their own. The acting manager had initiated some activities such as a Christmas Pantomime and Bonfire Night celebration.

Most activities involved only one or two people who lived at the home taking part at any time. Some people were not offered activities for time periods up to two weeks. One entry showed that the activity listed was for the activities coordinator to go shopping on behalf of the person to shop for an item of toiletry. It was not clear how this facilitated an activity for the person.

One relative told us that “As far as I am aware my family member has done no activities”. Another relative said, “Some of the residents want to go out but it’s limited”. A health care professional who visited the service regularly described the lack of activities as “Bordering on neglect”. They told us that staff have had to give their own time voluntarily to make sure that some activities happened. The staff told us, "Activities? What activities?”

The acting manager and senior centre manager told us the activities programme was subject to an improvement plan following our findings at the last inspection. An activity survey had been introduced by the provider to establish what activities people preferred but this had not yet been completed by most people.

The service had recruited a part-time interim activities co-ordinator who was available two hours twice a week. They told us, "I wish I could provide more hours to this service but I cannot. People here need someone full time who is jolly, enthusiastic and who can bring exciting options”. They told us that people who remained in bed needed more time to be spent with them than was being provided, in order to stimulate their interest. People were complimentary about this member of staff and were smiling when she came to talk with them. People told us she was "A welcome breath of fresh air" and "Cheering the place up no end, such a shame we don't have her longer and every day".

The interim care co-ordinator had started to engage people with sensory work and a person who needed visual stimulation was provided with a multiple lights projector angled at their ceiling and 'lava lamps'. The staff did spend part of the day chatting to people and engaging in activities such as playing on a computer with people. We have made a recommendation for improvement.

People’s personal records included a pre-admission assessment of needs, a personal profile, needs and risk assessments and an individualised care plan. This ensured staff were aware of people's needs before and during their stay. All care plans and assessments of needs were reviewed on a monthly basis or as soon as people's needs changed. One person's care plan had been updated to reflect a risk to their skin integrity and included monitoring measures for staff to follow. Another had been updated following a dietician and a specialist nurse's advice and contained new guidance for staff to follow. The instructions had been followed in practice. A new diet had been implemented and particular dressings had been used to protect a person's skin. People whose skin was at risk were repositioned in line with the instructions that were given to staff. Records of wound healing progress were appropriately documented to show that staff had implemented the recommendations. This showed that staff responded to people’s needs as they changed.

People were referred to specialist nurses and GPs in response to their needs. One person who had experienced difficulties with pain control had been referred to a multiple sclerosis nurse. We spoke with the nurse who told us, "I am quite happy with the way staff reacts to recommendations". A relative told us they were very satisfied about how their family members' wound had been managed. They said, "The wound has healed due to the staff giving it the consistent attention it needed".

People’s records of care and support were personalised to reflect people’s wishes and what was important to them. One person had expressed the wish not to be taken to hospital. A person enjoyed using a particular type of lip

Requires Improvement

Is the service responsive?

balm. Another person expressed the wish to participate in a cheese tasting session and these had been facilitated. A person wished to attend a day centre three times a week. People's individual needs had been responded to and staff offered care that was focussed on those needs and wishes.

The service took account of people's complaints, comments and suggestions. People were aware of the complaint procedures. A person who had complained about a specific lack of information told us this had been remedied without delay. Residents meetings were scheduled to take place every two months. At the last meeting which took place in November 2014, information was provided to people about staff structure and their wish to have the Internet installed had been discussed. The senior centre manager told us this facility was being explored by the provider.

People's relatives confirmed that they were made to feel welcome at any time to visit without restrictions. This reduced the risks of social isolation for people.

We recommend the provider seeks and follows guidance on providing activities that are meeting people's daily social needs and preferences.

Good

Is the service well-led?

Our findings

Our observations and discussions with people, their relatives and staff showed us that there as an open and positive culture which focussed on people. People and members of staff were welcome to go into the office to speak with the acting manager at any time. Two people's relatives told us, “The new manager is really approachable”, and "The service has really improved with the new management ". Staff told us, “The new manager is the best thing that's happened in five years". People said, "The place is better managed now" and, "I don't need to complain as much because I am heard more". A specialist palliative nurse who visited the service told us, "This is a good team and they are well supported. We are confident we will be working together better under this new leadership".

The acting manager told us of their vison relating to the running of the service. They said, “This home has enormous potential to become a model of its kind and lead the way in specialised care for people who live with a neurodisability”.

The provider had taken action to make sure there were suitable management arrangements in place in the absence of the registered manager. The acting manager had implemented positive changes in the service. This included monthly reviews of people's care plans and assessments, new staff training schedules, an increase of staffing level in response to a person's needs, new templates and a re-organisation and simplification of record systems. The acting manager had recognised where they were shortfalls in the service and had developed plans to make further improvements in regard to what people, staff and relatives had told them. This included food provision and activities but these had not been embedded into practice at this time.

People and relatives had an opportunity to give their views about the care and service during the annual satisfaction questionnaires. They were complimentary about the care they received.

Where gaps in records or a need for improvements to the service had been identified, action had been taken. A process of assessing people's mental capacity for the use of bed rails to minimise the risk of people falling from their beds had been completed. Supervision for staff had been provided or was scheduled. Wound care management was monitored daily to ensure the delivery of care matched specialist nurses' recommendations. An improved system of communication using a book and handovers ensured vital information was passed on between shifts. Some equipment had been purchased to assist daily activities.

The acting manager consistently notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders. This was confirmed by a local authority case manager who oversaw a person’s care in the service. They told us, “This manager communicates well with us and understands the problems of one particular case very well”.

The acting manager told us, "We need to increase physiotherapy input, daily activities and the quality of people's food " and, "I like to be on the floor and work with the staff and I want to delegate more responsibilities to the staff so they feel empowered and take more pride in their achievements. They will be happier in their work and happy staff make for happy people". Members of staff confirmed the acting manager was supportive and understanding of the challenges they encountered. They said, “She (the acting manager) has asked us for ideas and feedback so we can be more involved". The acting manager had plans in place to effect these changes.

Staff were aware of the service’s whistleblowing policy and that they were able to report any concern they or the people may have to the acting manager. They told us that they had confidence in the acting manager's response. A staff meeting took place in November 2014 and staff were invited to contribute to the agenda. Staff’s code of conduct was discussed at each supervision to ensure they understood what was expected of them. The acting manager had met with senior staff in September 2014 and these meetings were scheduled quarterly to discuss compliance with regulations, training, health and safety and quality audits.

The staff we spoke with were positive about the support they received. They told us, "We are encouraged to speak up, take more responsibilities and take pride in our work”. The housekeeper told us they had support from the acting manager to maintain good standards. The acting manager had yet to meet with all of the members of the staff team for one-to-one supervision meetings but we saw that they had met and discussed staff roles with nine members of the staff team and had plans in place to meet individually

Good

Is the service well-led?

with another 22 in the near future. Appraisals were scheduled to assess staff performance and identify their needs for training and studying to gain qualifications. There was a comment box available for staff if they wished to raise issues.

There was a system of quality assurance in place to monitor the overall quality of the service and identify the needs for improvement. The senior centre manager showed us the service's 'quality programme monitoring' system. The senior centre manager had scheduled an audit of staff files to ensure they all contained appropriate and complete documentation. All accidents and incidents such as falls, complaints or infection control issues were entered in the computerised system and scored according to their severity. We checked on the records related to a medicines error. The system could identify at a glance what happened, what immediate action had been taken, who had been notified and which documentation had been completed. The senior centre manager was then automatically notified and linked the information to previous incidents to identify any common triggers. Lessons learnt were discussed each time they met with the acting manager.

There was a system in place to ensure daily audits of people's records were carried out by the acting manager and senior staff. This ensured all documentation was complete for each person's care and treatment. There were monthly audits carried out on safeguarding adults, clinical room and medicines records, infection control, food safety and environmental audits. Audits included action that had to be taken when shortfalls had been identified.

Computers were password protected and were backed up by external system. This ensured people's confidential information was securely kept. Records were kept securely, archived for the appropriate period of time and disposed of safely.