Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: The Dean Neurological Centre is registered as a nursing home and provides rehabilitation, complex disability management, personal and nursing care services to 51 people who are affected by a range of neurological conditions aged 18 and over at the time of the inspection.

People's experience of using this service:
The provider had not made sufficient progress since our last inspection in May 2018 to ensure that people received safe care and treatment and met their regulatory obligations. Progress to improve the service had not been fully established and sustained due to changes in the management team and staff turnover and vacancies.

Since our last inspection, there had been several changes in the management team at The Dean Neurological Centre. A registered manager was in post however a senior leadership team was managing the day to day management of the centre. Prior to our inspection the provider had identified shortfalls in the service. The provider had arranged for a specialised 'support team' to be deployed to The Dean Neurological Centre to assess and address gaps in the service with the aim to improve people's quality of care and improve the clinical governance systems. The support team were working against an action plan to prioritise and address the needs of people with high clinical risks.

CQC and the local commissioners have requested weekly updates to discuss their progress in improving the quality of people's care and running of the service. The updates and action plans have provided CQC and other stakeholders with assurances that the provider was taking immediate action to address our concerns.

People were at risk of potential harm as it was not always clear if they had received care and treatment in line with health care professional recommendations and current evidence-based guidance. Staff had not always recorded their care provision or updated people's records to reflect the management of their current needs. Records of people's advance and end of life care had not been recorded to provide staff with guidance if people entered the final stages of their life. There was limited clinical oversight and effective systems being used to monitor people risks, progress and well-being. We found some areas of good practice such as safe management of people's mobility and hoists. However, safety concerns raised through the provider complaints and accident process had not been consistently addressed to drive improvements.

People had not always received personalised care in a timely manner as staff had at times not been effectively deployed to be responsive to their needs. People's care was not always personalised and centred on their emotional and social requirements.

Staff told us they could speak to the leadership team and registered manager but reported that management changes had impacted on their morale and well-being. The skills and knowledge of staff to support people with complex needs had not been sustained due to a high turnover in staff and use of

agency staff. The training needs and competencies of staff were being analysed and any gaps were being acted on. Plans were in place to ensure staff were trained in recognising early warning signs of changes in people's health and in current end of life care practices. Action was being taken to ensure people would be supported by sufficient numbers of staff who were familiar with their needs.

A recruitment campaign and training/competency analysis of staff skills was being undertaken to ensure people were supported by staff that could provide effective care and were familiar with their needs. Dedicated staff were working on an action plan to improve the management of people medicines and shortfalls found in a recent infection control audit and improve the quality and details of people's care records.

Staff were working more openly and collaboratively with external health care professional and relatives to improve the quality of care and improve positive care and treatment outcomes for people. Systems were being established to provide people with opportunities to express their views, suggestions and comments about living at the service. Learnings from accident, incidents and complaints had not always assisted the service to improve their practices. Progress was being made in improving the centre's environment and range of activities for people.

People and their relatives praised the kind nature of staff and told us they were kind and compassionate. People were treated with dignity and respect and their right to a private life was upheld. Where possible people were offered choice or staff supported them in their best interests based on people's likes and dislikes.

Rating at last inspection: At the last inspection the service was Requires Improvement (last report was published on 17 July 2018)

Why we inspected: The inspection was brought forward due to increased information of risk and concerns about the centre and based on the previous rating of the service. We followed up on progress against agreed action plans, to address the breach of regulation found at our previous inspection.

Enforcement: Full information about CQC's regulatory response to more serious concerns found in inspection and appeals is added to reports after any representation and appeals have been concluded.

Follow up: Following the inspection, we asked the provider to take immediate action and provide a weekly action plan to demonstrate the actions that have taken to address our concerns and to meet the regulatory requirements to improve the service. We are also working in partnership with other agencies to monitor the service.

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

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 not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 prompted in part by concerns raised by staff and health care professionals about the quality and provision of care at The Dean Neurological Centre.

Inspection team:
The inspection team consisted of three inspectors, an inspection manager, assistant inspector and a pharmacist inspector.

Service and service type:
The Dean Neurological Centre is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The 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 comprehensive inspection was unannounced.

What we did:
Before the inspection we reviewed information, we held about the service and provider as well as previous

inspection reports. We received information from the local authority and commissioners and other stakeholders linked to the service.

The provider was asked to complete a provider information return prior to this inspection, however we inspected before the submission deadline. The provider subsequently submitted their completed PIR. 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.

On 13, 14 and 15 May 2019, we spent time walking around the centre and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people and seven relatives. We looked at the care plans and associated records of twelve people. We also spoke with nine care staff, four nurse, two agency nurses, activities lead, four members of the senior leadership team, pathway manager, operations manager, head of therapy (by telephone), the registered manager and representatives of the provider.

We looked at six staff files relating to their training and personal development as well as the home's recruitment procedures. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and records relating to the management of the centre including quality assurance reports.

On 24 May 2019, we met with the new support team and representatives of the provider to discuss the immediate actions they were taking to address our concerns and findings. This information assisted CQC in assessing the immediate risk to people.

We received feedback from eight health care professionals after the inspection.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management
• People were at potential risk of not receiving safe and effective care in a timely way. Prior and during our inspection, CQC received information of concern from whistle-blowers and concerned health care professionals relating to the safety of people. They were concerned that people were at potential risk as they did not consistently receive safe care which was regularly monitored. Some family members reported to us that they felt their relative's health and clinical risks had on occasion been compromised and were not always well managed. For example, two relatives reported that they sometimes found their family member sitting or lying in incorrect positions which compromised their safety.
• The centre was being managed by a senior leadership team and supported by the registered manager. However, the registered manager did not have robust systems in place to assess and monitor people's health and clinical risks in accordance to guidance and health care professional's recommendations. For example, the registered manager and nurses were unable to always assess if people's nutritional needs were being met as effective systems were not continually used to monitor people's food and fluid intake and weights.
• A GP had prescribed a nutritional supplement and weekly weight monitoring for one person who was losing weight. These recommendations had been recorded in the person's evaluation notes and communication records, however their care plan had not been updated to reflect this change in care provision. From speaking with staff and checking the person's records, there was no clear evidence that the GP's recommendations were being carried out or effective systems were being used to monitor the person's nutritional needs and weight. Feedback from a health care professional confirmed that people's weights were not consistently monitored therefore they were unable to fully establish if people's nutritional and calorie intake was sufficient.
• People's care records did not always demonstrate if people had received care in line with their care plans, as staff had not always clearly and consistently recorded their delivery of care. For example, there was an inconsistent approach to the management and monitoring of the catheter care of one person which put them at risk of developing urinary tract related symptoms and infections. It was difficult to assess from the person's care records whether they received their catheter care or when they required care in line with their elimination care plan and health care professional guidance.
• Two health care professionals expressed concerns about the inconsistency of care provided to people. For example, one professional raised a concern that the person they supported was sometimes incorrectly positioned in their wheelchair and was not receiving the recommended therapy or daily rest periods. They felt that not all staff were always fully aware of people's individual needs and did not always work collaboratively with external health care professionals or their relatives in people's best interest. Another health care professional also felt the postural management and splinting regimes were not always

implemented correctly and monitored.
• From the records of people who required their medicines, fluids and nutrition via a Percutaneous endoscopic gastrostomy (PEG) tube it was difficult to assess if their care and treatment and the maintenance of their PEG was being carried out in line with best practice and health care recommendations as it had not always been recorded.
• Some people were living with epilepsy and required recovery medicines to be used at a specific time after a seizure. However, the management records of people's epilepsy care did not provide staff with detailed information or direction such as when to administer people their recovery medicines and when emergency services need to be contacted. One nurse was able to describe the support they would provide if a person experienced a seizure in accordance with recognised practice, however this practice not been clearly recorded. This meant people may be at risk of not receiving the correct care and treatment when they experienced a seizure.
• People were at risk of not receiving their medicines on time or receiving effective pain relief as pain management tools to assess the pain levels of people who were unable to communicate their pain and needs were not consistently used. Therefore, clinical staff did not always have the information they needed before assessing if a person required pain relief or additional medicines. Health care professionals reported that there had been insufficient numbers of devices to help administer people's medicines during palliative care, however this had now been addressed. Insufficient numbers of qualified nurses were available to administer people's medicines which meant that people may not receive their medicines on time. Systems were not in place to ensure people who required 'time specific medicines' received their medicines on time.
• Risk assessments on the management of people who required oxygen treatment were not evident.
• Most people had a personal evacuation and emergency plan in place, although the contents of the 'grab and go bag' (a bag that contains people's evacuation plans and equipment it assist in an emergency and share with emergency services) at reception would not be effective in providing emergency services with the information they needed to support people in the event of a fire. The emergency plan for people at night when fewer staff were on duty was not fully detailed in their personal emergency and evacuation plans.

People were at potential risk of harm as safe and effective systems were not continually being used to manage and monitor people's risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Since being in post, the provider's support team were making progress in improving the management and oversight of people's clinical risks. They were reviewing staff training, had implemented a new handover and clinical audit systems and had a re-introduction of daily and weekly clinical meeting with heads of departments and clinical staff to ensure all staff had the information and knowledge they needed to support people. This information also helped to inform the monthly multiple disciplinary team meeting where each person's needs and individual objectives were discussed and reviewed. However, further time was needed to ensure that the systems implemented were sustained and effective in the safe management and monitoring of people's clinical risks.
• We found areas of care which were being managed well. For example, where people required assistance with their mobility, there were clear and comprehensive plans in place to ensure they were assisted safely. For example, one person required assistance from two members of staff to assist them to mobilise. There were clear guidelines for staff to follow, including the equipment required and how to appropriately use these pieces equipment.
• Where appropriate, people received care and support to maintain their skin integrity. Staff achieved this by assisting people to reposition to reduce pressure on people's skin and by applying prescribed topical creams. Where people were supported to reposition, this had been clearly recorded, including how they had been supported. One person was assisted to reposition at a frequency set by nursing staff. This person had equipment, including an air mattress to help maintain their skin integrity.

• People were supported to take positive risks to improve their well-being. For example, the health benefits and risks for one person who used an electric powered wheelchair to mobilise around the centre and the local community had been assessed and regularly reviewed.

Staffing and recruitment
• We received mixed comments from people, relatives, staff and visiting health care professional about the deployment and availability of staff. We were told that on occasions insufficient numbers of staff had been on duty to ensure people's physical, mental and social needs were fully met. We received comments such as, "The turnover of staff is a problem. Staffing levels are not as high as they have been. Staff move on quickly", "Staffing at night times can be problematic, the manager is aware" and, "You can never find a care assistant or a nurse when you want one." One staff member described their care as 'task orientated' and said, "We don't have time to sit and spend time with people." Relatives and health care professionals reported it was sometimes difficult to find staff to help them with their questions or concerns.
• Due to staff turnover, vacancies and unplanned absences; agency staff had been used to support people. Where possible, regularly agency staff were used and had been trained by the service to support people with more complex needs.
• The service had recognised issues related to staffing and were taking immediate steps to manage the shortfalls. For example, agency staff were being block booked in advance to ensure people were supported by familiar staff. They were required to attend the provider's induction course and their competencies would be assessed before they supported people alone. The support team had reviewed and ensured that the nursing levels met the needs of people.
• The service was actively being supported by the provider's human resources team to promote and drive a recruitment campaign to recruit staff at all levels and reduce the use of agency staff, including senior clinical staff and management. Recruitment procedures were in place to ensure suitable staff were employed including employment and Disclosure and Barring Service checks (criminal records and barring checks) on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with vulnerable adults.

Using medicines safely
• Records showed that people received their prescribed medicines. however, further progress was needed to ensure people's medicines management was consistently safe.
• Protocols for medicines which had been prescribed to be taken 'when required' were available, however some lacked detail about the symptoms staff should be aware of for each person to help them decide when these medicines should be given. Records of the rationale of the administration of 'when required' medicines and the outcomes for people who was not always evident.
• Appropriate arrangements to manage medicines which had to be given at a specific time were not in place. For example, a regime was not in place for one person to receive their medicines at the same time and frequency each day. This put the person's condition at risk and potential increased their dependency on staff.
• However, progress was being made in the safe management of people's medicines. We found evidence that some actions against the supplying pharmacist's recent medicines audit had been completed. The provider had assessed that the systems and management of people's medicines needed to be more efficient to mitigate errors and inconsistencies and had taken action to address the concerns raised. Additional provider pharmacy support from head office and from an adjacent provider location had started to support the centre to ensure the systems used to manage people's medicines were in line with current guidance and evidence-based practices.
• Communication between the centre, GP and pharmacist was more effective to prevent delays in people receiving newly prescribed medicines such as antibiotics.

Preventing and controlling infection
• Action was being taken to ensure the centre was clean and effective infection control and prevention procedures were being followed.
• Staff had been trained in infection control and were seen to be using personal protective clothing such as aprons and gloves appropriately. There were posters displayed to encourage robust hand washing.
• An infection control lead had been identified and was being supported to carry out regular infection control audits to ensure the centre was being effectively cleaned and meeting national infection control standards. Plans were in place to review the frequency of these audits which would ensure infection control practices were maintained and actions were taken when shortfalls were found.

Learning lessons when things go wrong
• Staff were aware of the need to report any concerns, accidents, incidents or near misses to the nurses or managers. All reports were reviewed by a member of the senior leadership team and analysed by the provider to identify any concerns or issues, however swift action required to address safety concerns had not always been taken. For example, the operating procedures and staff training had not been effective in providing guidance to staff to correctly manage accidental damage of people's PEGs in line with best practice.
• Information and actions taken relating to incidents were shared at the daily huddle meetings, however, there was limited evidence that the service learnt from the incidents and used this information to reflect on their systems and drive improvements. People's care plans had not always been updated to provide staff with up to date guidance to reduce the risk of repeat incidents. For example, the management and actions to be taken for one person who had removed their PEG had not been updated to inform staff of the actions they should take.

Systems and processes to safeguard people from the risk of abuse
• Not all staff had received refresher safeguarding training, however we spoke to staff who had a good understanding of the provider's safeguarding policies and procedures. Staff were clear about their responsibilities to report any suspicions of abuse and whistle blow if they had any concerns about quality of care. They told us they would contact external agencies if the registered manager did not act on their concerns. Systems to escalate concerns in an open and honest manner without any repercussions were being readdressed and discussed with staff, people and their relatives. Regular meetings and communication between staff, relatives and the managers were being implemented to help build relationships and confidence in the management team.
• Some people and their relatives told us they felt safe living at The Dean Neurological Centre and were protected from discrimination and abuse. For example, one relative said, "I do feel it's a safe place."

Requires Improvement

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• When assessing people's needs, staff used universally recognised assessment tools that took into account nationally recognised evidence-based guidance. However, people's care and treatment was not continually delivered in line with recommendations and guidance.
• The registered manager had not ensured that all staff had the appropriate skills to support people and the actions they should take if people became unwell. Some health care professionals reported that the management and timing of people's hospital admissions had not always been appropriate. Not all staff had the knowledge and skills to effectively assess and monitor people's wellbeing, detect early symptoms and take appropriate action. For example, best practice guidance around the management of people's epilepsy and diabetes had not always been maintained which had resulted in two hospital admissions. There was no overarching management plan for one person who required their diabetes to be managed through prescribed medicines. Information about symptoms which may indicate their diabetes was becoming unstable and the actions staff should take were not clear.
• Health care professionals reported that recorded information about people's current needs, presenting symptoms and treatment objectives were not always clear when people were admitted and discharged from hospital. Therefore, staff were not always fully informed of people's treatment plans in line with clinical guidance.
• The support team had identified and were addressing the shortfalls in staff competencies and systems to assess and monitor changes in people's health in line with evidence-based guidance. For example, a training programme was being rolled out to upskill and train staff in an assessment tool specifically designed to help monitor the well-being of people with neurological conditions.
• People benefited from the support and expertise of a multi-disciplinary team and rehabilitation medicines consultant who assisted in monitoring their health needs and making recommendations to sustain their well-being and achieving positive outcomes for some people.
• The provider employed a multi-disciplinary therapy team to provide additional funded support and rehabilitation to assist people in maintaining and progressing in their physical well-being such as mobility. For example, through the dedication of the therapy team, one person who had been admitted to the centre with complex physical needs was now mobile.
• Some people had made progress in their well-being while living at the centre. For example, where possible people had been assessed and supported to reduce their dependence on equipment which had assisted them with breathing or nutrition intake. A health care professional reported that staff worked as a team and followed guidance and raised any concerns when people had been assessed as no longer requiring a tracheostomy or PEG.
• People's independence was promoted through the use of technology. One person had a device which

enabled them to control their environment by tapping their head against a device which was placed on their head. This enabled them to turn their television on and off and make a call for staff assistance. Another person had been supported with special equipment to enable them to take more control playing video games.

Staff support: induction, training, skills and experience

• People had not always been supported by staff who had been assessed as competent to support people with complex needs. Some health care professionals raised their concerns about the competencies and knowledge of care and nursing staff as staff had not always supported people using current best practice. For example, appropriate and timely referrals to health care services had not always been carried out as not all staff had been trained in areas such as identifying early warning signs of people's physical deterioration. Some staff had not completed their refresher training in line with the provider's mandatory training requirements.

• The provider's actions to analyse and ensure staff were suitably trained and competent had not been fully sustained due to changes in care and nursing staff and staff responsible for managing and monitoring staff development. However, the support team were taking immediate actions to identify and act on any gaps in staff knowledge to ensure people were being supported by staff who had the skills to meet their needs. We were told their priority was to ensure that staff had the most up to date skills and were familiar with the provider's protocols and operating procedures. A member of the support team said, "We are going back to basics and want to be assured that the staff have got the right skills to care for our residents." There was evidence that staff were being booked on refresher courses such as moving and handling and prompted to complete the provider's mandatory training. Additional training, such as, in leadership and critical care training had also been planned. However more time was needed to ensure all staff were fully trained and assessed as competent to carry out their role.

• Specialist health care professionals had been approached to help to deliver specialist training such as PEG and tracheostomy and ventilation management. All new staff were provided with a comprehensive induction period including training and shadowing experienced colleagues. They were supported to complete the Care Certificate (a nationally recognised set of care standards).

• Nurses felt they were supported to develop and maintain their professional skills. One nurse told us, "I have the training I need, there is always training available for us to access."

• Staff felt supported by their immediate colleagues and in the senior leadership team, however they told us the recent changes in the management structure had affected their morale and direction for support. Staff reported they had received some supervision sessions although their line management support had changed. Plans were in place to review the management structure and opportunities for staff to be supported and discuss their professional development to ensure staff received regular supervision and an annual appraisal to review their work practices and personal development objectives.

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

• People were not always supported to maintain a healthy diet and adequate fluid intake to ensure they maintained a healthy body weight.

• The management of people's nutritional intake was not always recorded. For example, staff had sought the guidance of dieticians to ensure people's dietary needs were being met. Records showed that a dietician's recommendations for one person who was losing weight had been implemented and monitored. However, information about the management of another's person weight loss had not been recorded. Records indicated that they had lost a significant amount of weight between February and March 2019 and there was no recorded information about their nutritional management plan or further weight monitoring. We discussed this concern with a nurse who told us the person had chosen to lose weight using a commercial weight loss plan. Guidance for how staff should support the person to maintain a healthy regime of weight loss had not been recorded or fully monitored.

• People told us they were required to make meal choices from a set menu a week in advance. Most people told us they enjoyed the meals provided, but sometimes could not remember their food choices from a week ago. Alternative meals and specialist diets were catered for as required.

Adapting service, design, decoration to meet people's needs
• The design of the centre met people's needs. Wide corridors and doorways allowed people to move around the centre freely. Progress was being made to decorate the centre and make it homelier. Inspirational quotes and restful pictures and decorations were seen around the centre.
• Equipment used to support people such as hoists, and slings were being reviewed, updated or replaced.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• Some health care professionals felt staff had not always carried out their recommendations and escalated concerns about people's wellbeing in a timely manner and had requested support either too late or early. Their concerns have been reported in the 'Is the service safe?' domain of this report.
• People were supported to access health care services such as an optician and dentists. However, where people had been seen by external healthcare services there was not always a clear record of the support they had received or the outcomes of their appointment. For example, one person had an optician appointment which stated they would benefit from a specific set of spectacles. There was no record if this recommendation had been acted on or if the person had new glasses.
• The service had a close relationship with the GP who carried out daily visits to the centre to review any changes in people's needs, refer to specialist support services and review people's medicines. Health care professionals reported that they felt the service was becoming more open and co-operative in working in partnership with specialist services.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Mental Capacity assessments had been completed for people who were required to make significant decisions around their care and treatment. Records of assessments using the principles of MCA and outcomes were not always clearly recorded. For example, one person was assessed as not having mental capacity to make a decision regarding their speech and language therapy needs, however there was no guidance in place on how their speech and language therapy needs would be met in their best interest.
• Where people had been assessed as having the capacity to make decisions in their care, this had been clearly recorded and people's voice and choices were documented. For example, where people had mental capacity, they had been informed and supported to make decisions around their healthcare needs and risks. For example, one person had made a clear advanced decision that they did not wish to have a PEG tube inserted to receive nutrition and fluids, if their health deteriorated. In consultation with the person, staff and other health care professionals it was agreed when required they would receive their fluids through a syringe.

• Where people were living under DOLS, appropriate assessments and authorisations had been carried out. The service took appropriate action when DoLS were expiring to ensure the authorisations remained appropriate and in place. However, it was not always clear from people's records, how their deprivation of liberty was being managed in the least restrictive manner or how any conditions as part of the authorisation was being achieved or monitored.

Good

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People continued to be supported by staff and managers who were compassionate and caring. People and relatives made comments such as; "Staff are hardworking, dedicated and funny. They want to do the best for their residents, they give you a help when you need it", "Managers always say hello and give you a smile" and "Lovely, living here. I have made friends here." Other people described the staff as "Caring" and "Excellent." One health care professional wrote to us and said, "There is no question that all the patients at the Dean are cared for with compassion, empathy and on an individual basis."
• We observed that staff had developed a good rapport with people. We observed a relaxed atmosphere around the centre with pleasant and friendly exchanges and conversations between people and staff in the lounges and dining rooms. Through observations we saw, staff demonstrated a kind and considerate attitude. When talking to people, most staff bent down so they were at eye level and held their hand or touched a person's shoulder. Staff understood people's different communication needs and how to communicate with them effectively. The ways in which people expressed their views and the support they needed to aid communication and reading were recorded in their care plans.
• We saw some genuine and caring interactions between staff and people. Staff spoke to people respectfully and enquired about their well-being. Staff approach was friendly, and we heard people laughing at friendly and light-hearted banter and comments.
• People's bedrooms were personalised to suit people's wishes and preferences. For example, photographs of people's families and items of personal interest were displayed in their bedroom. A refurbishment programme to decorate the centre was underway. People had access to a pleasant decking area where they could spend time in the fresh air, eat their meals or socialise. Relatives said the decking area was a great asset to the centre and provided them with an area which gave them some privacy, space and tranquillity.

Supporting people to express their views and be involved in making decisions about their care
• People were offered day to day choices about their care and support whilst being encouraged to be as independent as they were able. For example, people were given specialist cutlery to help them eat independently if required. Where people were unable to communicate, staff supported people in their best interest such as providing them with their preferred drinks.
• Staff were encouraging people to make a 'wish list' and supporting them to achieve their wishes and dreams such as horse riding and attending concerts.
• Where possible, people were supported and encouraged to give feedback about the service they received. People were invited to attend the monthly 'fun committee' and/or residents meeting to provide feedback and make suggestions about activities or improving the centre's environment such as proposing ideas for the garden, menus or bringing up concerns such as laundry issues. One person confirmed their participation and input and said, "I get involved through residents' meetings, we talk about the food and activities" and "I

like helping on the fun committee". They told us the staff and managers were being proactive in helping to make changes around the service such as improving the environment and sourcing funding for a minibus to help people access the wider community.

Respecting and promoting people's privacy, dignity and independence
• People told us their personal care was provided in a way which maintained their privacy and dignity. For example, staff ensured the door was closed and that people were not unnecessarily exposed whilst being assisted with personal care. One person said, "Staff treat me with dignity and respect". We asked staff how they supported people's privacy and dignity. One staff member said, "We need to check ourselves to make sure we don't just walk into people's rooms. It is their private space." They went on to explain how they ensured people were covered when providing personal care.
• People were well-dressed and well-groomed which helped to maintain their dignity. At lunch time we saw staff help people to put on aprons to protect their clothing.
• Relatives reported that staff were respectful and friendly towards them and they felt welcomed. One relative said, "I'm always made to feel welcome. I can buy a lunch if I want to which is very helpful. I like that I can eat a meal with [name] and its sociable." Relative's pets were welcomed in the centre and enjoyed by people, their visitors and staff.

Requires Improvement

Is the service responsive?

Our findings

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

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

At our last inspection in May 2018, we asked the provider to take action to make improvements to records of people's care. At this inspection, we found this action had not been fully completed and had not met the requirements of Regulation 17 of the Health and Social Care Act
2008 (Regulated activities) Regulation 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; end of life care and support

• Since our last inspection, members of the senior leadership teams had started to review the quality and format of people's care records. However, the registered manager had not ensured that sufficient progress had been made to ensure people's care records were up to date and records reflected their current needs and support requirements. Agency staff and visiting health care professionals could not always easily access specific information they required as different styles of care plans had been introduced therefore there was no standardised format. For example, records of people's weights were documented in different parts of people's care records.

• The registered manager could not always be assured that people had received personalised care as consistent records of the management and monitoring of people's personal risks and delivery of care had not always been maintained. This meant people were at risk of not receiving appropriate and personalised care. For example, it was unclear from one person's care records if they had received regular catheter changes in line with a professional's recommendations.

• Some health care professionals reported that communication from the service and people's care documents were not consistently comprehensive. They told us staff were not always knowledgeable about people's current needs and found it difficult to assess from the care records on people's progress and whether their recommendations had been consistently acted on.

• People's care records had not always been updated promptly following accidents or incidents to ensure staff always had current information about the care people required.

• The oversight, management and records of people's end of life care and wishes was not always consistent. Personalised and comprehensive end of life care planning was not in place for people to ensure they staff had the guidance they needed to support if they entered the final stage of their life. Agreed treatment plans were not always in place to identify and optimise the best place of care and treatment for people. There was limited evidence that people and their relatives had been involved in discussions and decisions about their wishes and future care planning if their health deteriorated.

• Our continued concerns about the quality and detail of people's care plans and associated records meant the provider had not made sufficient progress since our last inspection in ensuring that each person had accurate and complete records of their current and future care needs.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

• A new format of care plans had been developed and was being introduced and managed by a care plan pathway manager. We found that a one-page profile had been implemented for each person which gave staff an overview of people's support needs, risks and emergency contact details. The new care plans were clearer and provided staff with more detailed guidance on they should support people, however only 10% of care plans were in this new format and further development was needed to ensure that they were person centred and reflected people's emotional and social well-being.
• Plans were in place to speak to people and their relatives and record their end of life wishes and treatment plans.
• People who were able to communicate with staff received care which was personalised and mainly responsive to their requests. However, this approach was not always consistent for people who were unable to communicate their needs and preferences. From our observations, we found delivery of care to some people was often task focused and staff did not always see the person as an individual. For example, one staff member moved a person in their wheelchair without any explanation of why they were being moved. We observed two staff members removing a sling from behind one person with very little explanation of these rationale behind their actions.
• People's dining experience and support with their meals was not always person centred. For example, staff were not always aware how their verbal and body language/positioning had a negative impact when supporting people. We observed some staff spoke, reached and stood over people while they supported them with their meals. Staff did not always explain how and why they were supporting them.
• During our lunchtime observations, we found some people's mealtimes were disrupted by staff speaking over them or not effectively being supported to eat their meals. For example, an agency staff member had not been fully informed of the support and adaptive cutlery that one person required to promote independent eating. The person's mealtime was constantly interrupted while the staff member fetched the appropriate cutlery and sought advice from other staff. This experience was not dignified for the person.
• Another person's anxieties could have been avoided if they had felt listened to. On the first day of our inspection, they had expressed their concerns about visiting the dentist the following day, however on the day of the dentist appointment, the person became very anxious and upset as the travel arrangements and the staff member made available to support them had not been made clear to them.
• From reviewing people's care records and our observations and conversations with relatives, we found people's care needs were not always consistently met and delivered in line with their care plans and health care professional's recommendations. We observed that some staff were not always familiar with people's personalised needs and support requirements. Some relatives had to remind staff to complete people's personalised care which was important to the person's well-being and health. For example, some staff were prompted by relatives to put people's splints on, correctly position people in their chairs and have their daily shave. We heard two relatives discussing this concern and one said, "You know what staff are on duty by the way dressed and positioned in the morning. It's a lottery"
• There was not a consistent approach to ensure people received their support and treatment in a timely manner. People reported that on occasions they had to wait for assistance or to be supported to have their meals.
• Health care professionals and relatives reported that staff had not always responded to concerns raised by family about changes in people's clinical needs. Referrals to specialist health care services had not always been completed in a timely manner to prevent hospital admissions.
• Progress was being made regarding the range of activities being provided at the centre. People told us they enjoyed sensory sessions, quizzes, exercise sessions and the regular visit from pat the dog. Where possible, people were supported to access the local community events and clubs of interest such as horse riding and sailing. However not all people received social and recreational support which was personalised and meaningful to them. Some people reported that they were bored and did not always have access to

activities which met their personal interests. We received comments such as "Not enough activities to do" and There is no WIFI available in my room, this is something I would like to change." Whilst we observed staff enquiring about people's well-being while they were passing; there were times where staff missed opportunities to socially interact and fully engage with people.
• People reported and from our observations, staff were not always effectively deployed to maximise opportunities for them to deliver person centred care in a timely manner. For example, staff did not always have time to socialise with people or promptly responded to their requests for assistance and monitor people who were left unsupervised. The use of agency staff meant that people were not always supported by staff who fully understood their personalised needs.

People did not always receive personalised care which was responsive to their personal and social needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Person centred care)

Improving care quality in response to complaints or concerns
• Records showed that people's and relative's complaints had been managed in line with the provider's complaints policy. There was evidence that people's complaints had been acknowledged, investigated and people had received a response from a senior manager. However, there was limited evidence that the learning from the complaints had helped the managers to analyse themes of the concern and taken action to drive improvements such as complaints about staff shortages.
• However, we received mixed message from people and their relatives about the responsiveness of staff and managers to their concerns and complaints. Most people told us that staff and managers had been approachable and had listened and acted on their concerns, however others felt their concerns had not been fully resolved. One relative explained, it had been difficult to get a comprehensive response from the staff and managers due to the constant staff changes.

Inadequate

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• The provider has continually failed to ensure The Dean Neurological Centre meets the Health and Social Care Regulations 2014. Since December 2016, the service has been inspected four times (including this inspection) and has repeatedly received the overall rating of requires improvement and with identified breaches of regulations. The provider has therefore not demonstrated that they are able to consistently meet and sustain the requirements of their registration and be compliant with the Health and Social Care Regulations.

• Where issues had been identified from the last inspection, it was not clear how their actions and progress had been sustained as we continued to find shortfalls in relation to people's care records and the management of their care needs and risks, medicines management, end of life care and comprehensive clinical governance systems.

• The registered manager was aware of their responsibilities to run a caring and effective service which protected people from harm, however they did not have suitable arrangements in place to assess and be assured that people received care and treatment which was safe, effective and responsive to their needs in line with the provider's regulated activities.

• The provider told us they had difficulty in retaining suitably qualified care and clinical staff however they had recruited a senior leadership team to help address concerns and improve the quality of care being provided to people.

• This inspection was carried out in part due to concerns raised by people, relatives, staff and other stakeholders. Throughout and after our inspection, some people, relatives and staff continued to raise concerns to CQC about staffing levels, high use of agency staff and the inconsistency of management and oversight of people's care.

• Concerns raised by the senior leadership team and findings from the provider's governance systems and internal audit (carried out in March 2019) had not led to sufficient improvement to address and meet the regulations in a timely manner. A recent disconnection between the senior leadership team present on our inspection and representatives from the provider had resulted in shortfalls in reaching and sustaining their mutual goal of improving the care and safety of people.

• Several changes in the management and leadership team of The Dean Neurological Centre during the last year had impacted on the service and the quality of care being provided to people and staff development. Management changes had resulted in people not always receiving a comprehensive response to their concerns or a sustained point of contact.

• People, relatives, staff and other stakeholders reported that they had been confident in the present senior leadership team, however felt actions taken and new systems to improve the quality of care being provided

had not been sustained. One relative said, "Lots of management changes, not sure if they're having a positive impact as they've not been here long enough." Staff reported there had been constant changes and did not always have access to clear clinical support and direction. Health care professionals reported they found some individual staff very knowledgeable but often worked in isolation.
• Staff did not always have access to the provider's policies and protocols to provide them with sufficient guidance to support people. For example, guidance of the actions staff should take when people's Percutaneous Endoscopic Gastrostomy (PEG) tube is accidently removed was not in place.
• CQC had not received any notifications about significant events or incidents since November 2018. From the provider's accident report and governance systems it was difficult to assess if some incidents had been notifiable. Therefore, the registered manager and provider had not always ensured that they had met their legal obligations to notify CQC of notifiable incidents such as serious injuries and the authorisation of DoLS applications.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care
• The registered manager had not ensured that the clinical governance systems used to monitor people's safety and reduce risks of harm had been effective. There was limited clinical oversight and accountability to ensure people's personal risks and health care needs were continually managed and monitored. As we reported in the key question 'Is the service safe?' lack of clinical oversight placed people at risk of for example not receiving the care they required to manage the risk associated with their weight loss, catheter care, epilepsy and diabetes.
• The senior leadership team and provider had not always used the information and concerns raised in people's feedback, complaints and accidents and incidents effectively to help identify any shortfalls and drive improvements. For example, incidents and complaints relating to concerns about staffing levels which had impacted on people's care had not been adequately addressed to prevent incidents reoccurring.
• The systems used to communicate and keep staff informed of people's current health needs were not always effective. For example, information shared during staff handovers did not continually prompt staff to check and monitor those people with specific and complex health risks.

Systems that had been put in place to assist in monitoring and mitigating risks relating to the health, safety and welfare of people had not always been sustained and operated effectively. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• As part of our inspection, we asked the provider to take immediate action to address our concerns relating to people's clinical risks and provide us with an action plan on how they planned to ensure people were kept safe and sustain sufficient management oversight and accountability due to recent management changes at the centre.
• The senior leadership team and provider and their representatives had identified concerns similar to our findings. They had drawn on their in-house resources and specialists to address the shortfalls found. Shortly after our inspection, a provider 'support team' with specialist neurological knowledge was tasked with the immediate role of identifying concerns and address the gaps in the management of people's care, staff development and governance of the centre.
• At the end of our inspection, we met with representatives of the provider and support team and were provided with an action plan about their short, medium and long term actions to address our immediate concerns and how they planned to implement and embed new systems and change the culture of the centre. This plan gave us some initial assurances, however further time was needed to fully embed and evaluate the new systems to ensure they resulted in positive outcomes for people.
• The support team was proactively working and meeting with people, relatives, staff and stakeholders to improve communication and promote open relationships with the aim to improve care for people who live

at The Dean Neurological Centre.
• Each person's care provision and associated health and medicine records were being reviewed to ensure they reflected people's current care, risk and treatment needs and consent to care.
• Plans were in place for staff to receive training in end of life care and recognising signs of people's health becoming unstable were being sourced and implemented. Staff planned to sensitively consult with people and their relatives and specialised health care professionals and record people's end of life wishes, support requirements and advance plan of treatment and care and resuscitation plans.
• The structure and frequency of clinical governance meetings and handover practices between staff was being reviewed to help better guide, reinforce and monitor the support needs of people with clinical risks.
• Progress was being made to train and assess the competencies of staff to ensure they had the appropriate skills and knowledge to support people with highly complex needs in line with evidence-based guidance. Additional training was being planned to upskill staff in specialist areas such as diabetes.
• The provider was taking immediate action to address the recruitment and retention of staff at various levels, including the recruitment of a matron, clinical leads and nurses to improve the clinical oversight of the service.
• Changes were being made to people's experience of living at The Dean Neurological Centre. For example, changes were being made to enhance people's dining experience and social activities as a result of the manager's observations and audits of people's social and emotional needs.
• The centre was well maintained. Records and certificates showed fire systems and equipment, electrical systems, gas installations and lifting equipment were tested at appropriate intervals. A maintenance team had oversight of these checks, which had been completed on a regular basis to ensure equipment and premises was safe. For example, regular water temperature checks and cleaning were carried out to help mitigate the risk of legionella bacteria in the water system. Health and safety meetings were held regularly and addresses any issues and assisted in standardised safe practices.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People, their relatives and staff felt the registered manager and senior leadership team present on our inspection were approachable and listened to their concerns, however due to the management changes, some people felt that their concerns had not always been fully resolved. For example, relatives told us they had to frequently raise concerns about repeated issues such as people's personal appearance, laundry and postural management. One relative said, "You make a complaint, it improves, staff change and we are back at square one."
• Since our last inspection, we found systems had improved to engage and receive feedback from people and their relatives about their experiences. People were given opportunities to raise concerns and make suggestions through regular 'resident and fun committee' meetings. The support team were improving their engagement with people and relatives and keeping them informed of changes in the centre.

Working in partnership with others
• Health Care professional and other organisations associated with the Dean Neurological Centre told us some progress had been made in improving links with specialist services. One health care professional said, "Its early days yet but we are finding they are working more in tangent with us and reaching out for some advice and support rather than silo working."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care which was responsive to their personal and social needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at potential risk of harm as safe and effective systems were not continually being used to manage and monitor people's risks.

The enforcement action we took:

We have issued a positive condition against the provider's registration for the location requiring the registered person to undertake a monthly audit to ensure people's risk are safely being managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems that had been put in place to assist in monitoring and mitigating risks relating to the health, safety and welfare of people had not always been sustained and operated effectively.

The enforcement action we took:

We have issued a positive condition against the provider's registration for the location requiring the registered person to undertake monthly audits to ensure people received safe care and treatment.