Four Seasons (DFK) Limited

Peter Gidney Neurological Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 11 April 2017. The inspection was unannounced.

The Peter Gidney Neurological Care Centre is registered to provide accommodation and personal care with nursing for up to 26 younger adults. There were 24 people living at the service on the day of our inspection.

The people living in the home all had a neurological condition such as recovering from a stroke or an acquired brain injury caused by an accident or medical condition. Some people had limited mobility and could walk around with support, whilst others relied on a wheelchair or full staff support to get around. Some people were nursed in bed and some people required support to communicate their needs and wishes.

The Peter Gidney Neurological Care Centre is a purpose built property that is spacious but in some need of improvement. The provider had plans to refurbish the premises in order to provide a more conducive environment for the people living there. The service was set in a quiet location away from busy main roads and with pleasant gardens with flowers, shrubs and trees.

A registered manager was employed by the provider to manage the service, however they were not available as they were absent from work. A temporary manager with the relevant experience and qualifications was managing the service in their absence. 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.

The provider had previously been registered with the Care Quality Commission (CQC) at this location. However, they had changed the legal entity of this service and this required them to apply for a new registration with CQC, which commenced on 30 October 2016. The service had continued within the same premises and with the same staff team and registered manager. This was the first inspection under the new registration, however, you can find previous inspection reports on the CQC website.

People were kept safe as the provider had systems and procedures in place to protect people from abuse. Staff understood their responsibilities in keeping people safe and felt confident to raise any concerns they had with the management team. Staff told us they thought any concerns they had would be taken seriously but they knew who to go to outside of the organisation if they were worried.

The manager made sure any risks faced by individuals had been identified and control measures put in place to manage the risk to keep people safe. Medicines were managed safely and effectively by registered nurses. People had a comprehensive care plan that provided detail of the individual support they required. People and their family members were involved in developing and reviewing their care plan.

Although a timetable of activities were in place that people could take part in, these were not suitable for some people living in the service. People did not get the opportunity to go out away from the service very often and told us they would like to. We have made a recommendation about this.

People were supported to eat and drink enough to meet their needs. People with specialist nutritional needs were supported appropriately on an individual basis. People also received the support they needed to maintain their health and well-being and to access healthcare services.

Environmental risks of the premises and grounds had been assessed and managed to keep people, staff and visitors safe. All essential maintenance and servicing of equipment had been carried out. Fire safety had been carefully considered and all appropriate measures to prevent fire and to keep people safe in the event of a fire had been undertaken.

The service supported people with complex health care needs. There were enough registered nurses and care staff deployed to be able to support the assessed care needs of people using the service. Safe recruitment practices were carried out by the provider to ensure people were only supported by staff who were suitable to work with people who are vulnerable as a result of their circumstances.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider, management team and staff understood their responsibilities under the Mental Capacity Act 2005.

Many staff had worked at the service for a number of years and were happy in their role. The service had an atmosphere that was friendly and welcoming. Staff knew people well and took this into account when providing individual care, supporting people to remain as independent as possible.

People, their relatives, friends and visiting professionals were asked their views on a regular basis. This was made easy to do by an electronic tablet system. Feedback was analysed by the provider and used to improve the service provided.

Although the registered manager was absent and had been for some months, the provider had ensured a suitable replacement was in place to manage the smooth running of the service. The staff team were happy with the arrangement and felt well supported. Although staff supervision had not been regular, the temporary manager had a plan in place to address this issue. Registered nurses and care staff had received the training necessary to carry out their role and to support people's complex health needs.

The provider had a robust approach to quality assurance, making sure systems were in place to check the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained and kept up to date in safeguarding adult procedures, and knew what action to take to keep people safe.

Individual risk assessments were in place to protect people from harm or injury.

Accidents and incidents were monitored to identify any specific risks, and how to minimise these.

Medicines were managed well by registered nurses to ensure safe administration.

Staff were recruited safely, and there were enough nurses and staff to provide the support people needed.

Is the service effective?

Good

The service was effective.

Staff received the on-going training they required to carry out their role. A plan was in place to ensure one to one supervision meetings and annual appraisals took place.

People's human and legal rights were respected by staff. The management team and staff had knowledge of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People had choices to make each meal time from a menu. People were supported with their specialist and complex nutritional needs.

Nurses were knowledgeable about people's health needs, and supported people to maintain their physical and mental well-being

Is the service caring?

Good

The service was caring.

The service had an atmosphere that was friendly and welcoming with a stable staff team.

People were fully involved in making decisions about their care and staff took account of their individual needs and preferences.

Staff protected people's privacy and dignity. Staff were encouraging and supportive to help people to be as independent as possible.

People were happy and told us they were well supported by staff who cared.

Is the service responsive?

Good

The service was responsive.

People's care and support needs were assessed before moving in to the service and care plans were produced, identifying how people wanted their support.

People, their relatives and friends were given the opportunity to give their views of the service provided and these were used to make improvements.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focused on people. Staff spoke highly of the management team in place and felt they were listened to.

The provider had robust quality assurance and monitoring procedures in place. The results of surveys were used to drive improvement to the service provided.

Records were clear and robust.

Peter Gidney Neurological Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 11 April 2017 and was unannounced. The inspection was carried out by two inspectors, one specialist nurse adviser and one expert by experience who has experience of a family member living in a care home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with seven people who lived at Peter Gidney Neurological Care Centre and a visitor, to gain their views and experience of the service provided. We also spoke to the manager, the unit manager, an administrator and five staff including two registered nurses. We received feedback from one health and social care professional.

We spent time observing the care provided and the interaction between staff and people. We looked at 12 people's care files, medicine administration records and staff records as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys

Good

Is the service safe?

Our findings

People told us they felt safe living at Peter Gidney Neurological Care Centre. We had many comments from people, these included, "I love it here, I feel really safe", "Yes, I do feel safe" and "It's all safe, no cause for concern."

People told us they would speak to the staff if they had any concerns to worry about. The guidance and advice staff would refer to about abuse if they had a concern to report was accessible through a comprehensive safeguarding procedure. Staff had a good understanding of their responsibilities in keeping people safe from abuse. Staff told us they would have no problem raising any worries they had and they were aware of who to contact outside of the organisation should this be necessary.

Registered nurses identified risks to the individual, assessing the risk and how to control and manage it. The risk assessments were comprehensive with robust guidance at every step for people and staff. Moving and handling risk assessments detailed the activity and what measures needed to be put in place to carry out the task safely. For example, guidance to support people with limited or no mobility transferring from their bed to a chair, with the aid of equipment such as a hoist and staff support. The equipment needed and how it was positioned was specified and the risks involved in using it for people and staff. Circumstances that would put people or staff more at risk when assistance was being given with moving around were highlighted. This included frail skin, the challenges associated with dementia or unpredictable behaviour, or a person's consumption of alcohol when being supported. Staff assisted people to move around safely with the aid of a hoist. Staff were knowledgeable and confident in their approach when supporting people to move around the home.

Some people had bed rails if they were at risk of falling out of bed. The risks associated with having bed rails in place had been identified for each individual and measures were in place to keep people safe. Measures such as, staff checking the safety of the bed rails every time they were in use and their continued safety every hour when people were in bed. In addition, records showed that the maintenance team fully checked bed rails every month.

All individual risk assessments were seen to be reviewed whenever there was a change in people's circumstances that may alter the impact of the identified risk, or where a new risk had developed. Reviews took place every month as a matter of course when changes had not been identified. This meant that people continued be kept safe from the risks identified as placing them at potential harm.

People were protected from the risks associated with the management of medicines. People were given their medicines by qualified registered nurses who ensured they were administered on time and as prescribed. In addition, two senior care staff had been trained as 'care home assistant practitioners' (CHAP's). They had received training over a 12 month period to enable them to assist the registered nurses. Medicines administration had formed part of this training. During the medicines administration round appropriate checks and recording were carried out to ensure that people received their medicines at the right time. Staff signatures and recording on the medicines administration record (MAR) were neat and

legible so gaps and errors were more easily identifiable. The ordering, receipt, storage and disposal of medicines was undertaken in a safe way following the provider's policies and procedures in relation to the administration of medicines. Some people had 'As and when required' (PRN) medicines. Guidance was in place for nurses and staff administering these medicines to follow which included the dosage, frequency, purpose of administration and any special instructions.

The room where medicines were kept was well arranged. Recordings were taken to check that medicines were stored within the correct temperature range to ensure their continued efficacy and safety. Emergency equipment was regularly checked and serviced, such as a suctioning machine used for people who required equipment to help with their breathing.

Medicines records were checked and audited regularly to ensure safe practice continued to be used. Registered nurses carried out a daily check, counting all medicines to make sure the numbers of medicines tallied with the recorded numbers. The nurse clinical lead undertook a weekly audit of medicines and the pharmacist who provided the prescribed medicines to the service carried out a six monthly independent audit. Checks were in place to ensure people received their medicines correctly and safely.

The premises were maintained to ensure the safety of people, staff and visitors. A comprehensive fire risk assessment had been carried out to ensure processes were in place to prevent a fire on the premises and to swiftly alert staff if a fire did break out. The servicing of fire equipment and alarms had been undertaken and were all up to date. People had a personal emergency evacuation plan (PEEP) located in the fire file and a copy kept within their care plan. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. The equipment used to assist people with their personal care needs, such as hoists and bath lifts were serviced and maintained to ensure they were in good working order. Regular checks and servicing of all other installations such as gas and electricity had been undertaken to ensure the premises remained safe and well maintained. Environmental risks were assessed and recorded, such as risks relating to the building and grounds. These checks enabled people to live in a safe and adequately maintained environment.

The provider had a comprehensive business continuity plan in place setting out the guidance staff would need if an emergency situation arose. Circumstances such as severe weather conditions or a loss of utilities were included in the plan. Relevant contact details including how to contact senior members of staff to support the situation were recorded.

Accidents and incidents were recorded by staff on the provider's electronic system, detailing the incident itself, who was involved, the outcome and the action taken. The manager reviewed incidents, checking that appropriate action had been taken and following up on outstanding actions. The manager and provider analysed the information to learn from trends and mistakes made in relation to incidents.

The provider used an electronic dependency tool so the management team could make sure the right numbers of staff were available to meet people's needs. Many of the 24 people living in the service required the assistance of two staff for personal care at any given time. People's dependency scores were reflected in the number of staff on duty each day. The dependency scores for each individual were updated on a regular basis to ensure staffing levels remained appropriate. . Agency staff were rarely used as the service had a stable staff team with many of the nurses and care workers having worked there for many years. The staff team covered staff absences such as annual leave or sickness. During our inspection the service was well managed and people's needs were attended to promptly and with care. The staff had time to spend with people throughout the day.

The service had robust staff recruitment practices, to ensure that staff were suitable to work with vulnerable people. Staff told us that they had been through an interview and selection process before they started working at the service. Checks had been made against the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with vulnerable people. Application forms were completed by potential new staff which included a full employment history. There were no gaps in people's employment that had not been discussed at interview or recorded on the application form. The manager had made sure that at least two references were checked before new staff could commence employment. There was an organised system within staff personal files which was kept up to date by the services administrator. The providers system allowed for all this information to be kept centrally but easily accessible when required by the management team.

All the nurses Nursing and Midwifery Council (NMC) PIN numbers were recorded and a system in place to check when the nurses registration with the NMC was next due. The nurses were also being supported with their NMC revalidation requirements and had been provided with a folder to keep their evidence to hand and also current. The provider was following safe recruitment policies and guidance when employing new staff to the service.

Good

Is the service effective?

Our findings

People told us they thought the staff knew how to support them and knew what they were doing. One person said, "The staff know what I want, I love everybody, they're lovely people" and another said, "Yes, I'm confident with the staff". Another person commented, "I'm confident with the staff and that they are able to provide the support needed".

New staff were required to complete an induction programme during their probation period so that they understood their role and were trained to care for people safely. Each new member of staff had a mentor during their induction who would work with them for several shifts and complete some of their induction programme. The Care Certificate (Skills for Care) was being introduced for new staff to the service as part of their induction and probationary period. The staff were well supported during this time especially if they were new to care. Staff were supported by shadowing other staff until they felt confident to do certain tasks unsupervised and had been assessed as competent to do so. Staff had completed mandatory training through face to face and e-learning. All staff had either completed the required training to meet people's needs or were in the process of completing it. The administrator had a system in place to remind all the staff when their training was due to be updated and when they had to complete it by. Staff were clear about what training they had received and confirmed they were reminded to complete the training when it was due.

People living in the home had various complex health issues such as epilepsy or requiring support with breathing or feeding. People's needs were met by well trained staff and any additional training that was required was provided as and when needed. The staff told us that training had improved as they were given the time to do this either at work or at home. Staff demonstrated a good knowledge of their work and how to keep people safe and receive the care and support they required. People were supported by staff who were well trained to provide appropriate care and treatment to improve their outcomes.

Staff supervisions had not taken place as often as the provider's policy stated, as the registered manager had been absent. However, it was acknowledged by the staff that they felt well supported by the management team and had received supervision since the last inspection. The manager stated this was an area they planned to improve. They had set up a plan of staff supervisions and appraisals which included an observed practice. This is where a staff member's supervisor works alongside the staff member for the day and then feeds back on what they have observed. The manager planned to use this as a valuable source of effective supervision of staff.

People living at the service had specialist nursing care needs. It was important the staff supporting them were led by qualified registered nurses who had the professional credentials to make sure people got the right care. The nursing staff were supported with their revalidation requirements with the Nursing and Midwifery Council (NMC). One of the senior nurses was the clinical lead for the service and they played a role in supporting the qualified nurses in revalidating every three years.

Within the service a number of support staff had been through the provider's new Care Home Assistant Practitioner (CHAP) role. This was developed as part of an industry-wide initiative to provide development

and additional training to care assistants who wished to have additional responsibilities. Two care assistants had recently completed their course and were about to graduate. The provider said that 'This role reflects the changing care needs of our residents and provides our most promising carers with the opportunity to take on more responsibility and develop their skills and careers'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity showed that this had been clearly recorded and decisions had been made in their best interests, each decision being treated individually and separately recorded. The manager understood when an application should be made and how to submit them. Care plans demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

People's rights, consent and capacity were assessed as part of the care planning process and within the principles of the MCA. This was reviewed regularly in case people's circumstances had changed. People's individual level of need around making decisions was explored with them, and family members where relevant. People's care plans clearly stated if people were able to make their own decisions without support and that staff should respect their wishes. People signed to say they gave their consent where this was relevant. For example, to have their photograph taken to use in their care plan, or to have bed rails in place for their own safety. Where people wanted family members involved with more complex decision making, this was recorded and it was evident that this happened regularly.

People responded positively about their experiences at mealtimes. These included, "The food is really nice. The choice is not bad and you can have seconds or thirds. The pie and mash is fabulous. I can have a drink whenever I want", "The food is very good, we have a choice, it's very tasty and I could have more if I wanted". A third person indicated in a very animated fashion that they liked the food and there was lots of it.

Lunchtime was busy and the dining room was full. There was a lot of chat and banter going on with a friendly atmosphere. The food looked appetising and was well presented. People had chosen from a menu and were able to ask for an alternative if they did not like what was on offer. Some people required assistance to eat their meal and people were not rushed and chatted with staff during their meal. People were offered snacks through the day and some people had a 'snack box' in the evening with a variety of preferred snacks.

Assessments took into account people's nutritional needs and support was provided where necessary. Specialist advice was sought when needed from dieticians and speech and language therapists (SALT). For example some people required food prepared to create a puree as they were not able to swallow whole food and some people needed their food cut into small pieces. A diet notification form was sent to the kitchen for each person to make sure they were provided with the correct diet and texture of food. Individual risk assessments were in place for those people who were at risk of choking with specific and detailed guidance how to prevent a choking incident and what steps to take if this did happen. Staff demonstrated a

good understanding of the various types of diet and textures of food individual people required. Staff monitored people's weight regularly to ensure they maintained a healthy weight and measures could be put in place quickly if this changed.

The nurse's liaison with other health care professionals was crucial to ensure medical treatment and intervention was monitored closely. GP's were contacted when necessary and visited regularly to treat their patients, advising the registered nurses regarding changes in medication or treatment. Regular entries were recorded in people's care plans, making sure an accurate record was maintained. The advice of other specialist health care professionals was regularly sought to ensure people had the most appropriate treatment to maintain their health and well-being. For example, there were regular reviews by community mental health teams and tissue viability nurses. A healthcare professional told us that there was regular access to the health services, confirming there were regular health checks and medication reviews at least every three months or when necessary. They also said they had no concerns about the care given in the service.

Registered nurses used their skill and experience to provide people's nursing care requirements. People nursed in bed at high risk of developing pressure areas had detailed risk assessments and care plans that were well recorded by the nursing staff. Registered nurses ensured their expertise informed health care plans that were used to advise and guide staff. For instance, people who were not able to eat food through the mouth and therefore required an alternative such as percutaneous endoscopic gastroscopy (PEG) feeding. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medication can be given without swallowing. The service catered well for people's specialist health needs, good nursing care was evident.

Good

Is the service caring?

Our findings

People said or indicated that the staff were kind and caring. People's comments included, "The staff are nice and friendly", "Everybody is very nice" and a third indicated the staff were both nice and caring.

While we were speaking with one person, a member of staff poked their head around the door and started singing. The person responded with the next line of the song. Both then laughed and made thumbs up gestures to indicate that they were feeling good. Throughout the day and on a number of occasions, people and staff gave each other 'high fives' indicating this was an acknowledged friendly gesture between them.

The service felt friendly and relaxed. Staff were not in a hurry and gave people the time to do what they needed to do without rushing. People got out of bed when they chose rather than before a set time. People got up at various times and stages throughout the morning and being served drinks and breakfast when they wanted them.

The staff were confident and skilful in their work and showed respect in their communication with people. They were very supportive and understood people's needs. For example, people were sitting in chairs or wheelchairs or nursed in bed and staff spoke directly to people, at their eye level.

The staff approach was caring and they knew the people they supported well. When staff took drinks around they asked each person what they would like to drink and how they liked their tea or coffee for example, without making assumptions.

Most of the staff team had worked at the Peter Gidney Neurological Care Centre for many years and clearly enjoyed their work. This meant that staff knew people well and were aware of their likes and dislikes and what and who were important to them. Staff clearly had good relationships with people as they were laughing and chatting together. One person commented, "The staff joke around, they're good, they know how to joke".

Supporting people to maintain and increase their independence was a key theme throughout the care plans. For example, staff were guided to actively support people to continue to maintain their independence in using a wheelchair to get around the service themselves. In order to ensure the success of the plan, people needed to be encouraged or assisted to change their position regularly, when in bed or in their chair, to avoid pressure areas developing which could result in restricting their movement.

People were fully involved in the development of their care plans and were able to make choices about their care that were recorded for staff to follow. For example, people who did not want to be disturbed at night for checks to be made or their position to be changed.

Maintaining people's dignity and respect were highlighted throughout the care plan. Staff were aware of the importance of preserving people's privacy at all times and demonstrated this throughout the day in their actions and discussions. Throughout the inspection staff knocked on open bedroom doors and said

people's name before entering. Staff made sure they communicated with people at eye level, particularly when speaking individually or asking a question.

Good

Is the service responsive?

Our findings

There were mixed comments from people about the activities on offer through the day. When asked what activities they took part in, the following comments were made, "Bingo, Ludo, go out in the garden and sit under the umbrellas from time to time", "Board games, bingo, singing, there was a choir in last week, karaoke" and, "I look at the TV all the time, it's my life". People told us they did not go out much, except into the gardens surrounding the service.

An activities lifestyle plan was included within the 'My choices' book, documenting what the person liked to do with their time and the current interests they had. A journal recorded activities each person had taken part in or attended. The people living at the service were a younger age group of people under 65 years of age, who said they would welcome the opportunity to go out more. One person said they would like to go out to the pub and another said they would like to go shopping regularly. People said they could go out into the garden and some took part in activities, however, the activities on offer did not suit everyone's taste. For example, the scheduled activity on the day of inspection was pet therapy which many people really enjoyed, however, if dogs were not of interest to some people there were no other choices. The scheduled activity for the following day was morning worship. Activities such as throwing bean bags through hoops and a game of group solitaire being organised through the day also but this again would not suit everyone and those who were more mentally alert. Everyone in the lounge was encouraged to join in and the member of staff was enthusiastic and energetic, complimenting people when they did well. A lot of people appeared to watch television, which people wanted to do and did enjoy talking about their favourite programmes, however the alternative choices were limited.

We recommend the provider takes advice from a reputable source to increase the opportunities available for meaningful activities to encourage stimulation and limit social isolation for people.

An initial assessment was undertaken with each person before a decision was made that staff had the skills necessary to support people with their assessed needs if they moved in. This led to the development of the individual care plan. People's care plans were set out well for ease of use by staff. A comprehensive dependency assessment had been undertaken with each person, recording whether their needs were high, medium or low for each area within the care plan. This was checked every month to ensure people's needs remained the same with a full annual review taking place for re-assessment. Care plans were detailed to ensure people were supported and assisted in the way they wanted and to make sure their needs were met by staff. All the areas of daily living where people may require care and support were included. Such as moving and handling, skin care, life style, breathing and circulation, mental health and well-being, communication and personal care. For example, some people had a catheter in place as their health needs meant they required this intervention. Step by step guidance for staff was recorded to ensure safe and effective catheter care was given to reduce the risk of infection and make sure people were comfortable. Most people required extensive assistance with their personal care needs. Care plans provided the detailed information staff required to support people as they wanted. For instance, how often they liked a bath or a shower or if they were able to carry out some of their own personal care tasks.

People had a 'Daily file' in their room with all the documentation staff needed to hand for ease of recording and access to day to day information about each person. For instance, the daily file held all regular daily check charts such as food and fluid recording, position change charts and bed rail checks. The individual moving and handling profile and diet sheets were also kept in the daily file. Staff recorded in the daily notes booklet within the file, documenting all contact and intervention with each person. The other important document within the daily file was the 'My choices' book, with all the important information about the person. 'My choices' included people's preferences, such as their interests, their preferred sleeping arrangements, what is important to them, for instance, how they liked to dress, how often they liked to shave, what perfume they liked to wear. This continued with 'My life history' which detailed all the information about people's life previously, their employment, their relationships – if they were married and had children for example.

People told us they knew how to make a complaint and who they would complain to. One person said, "I have no complaints" and would "talk to the managers" if the need to make a complaint arose. The provider had a complaints policy in place and details of how people could make a complaint was given in the corporate guide for people and their relatives. The policy had been reviewed in October 2016 and contained a statement about how the provider would meet its duty of candour obligations. This gave clear details of what people needed to do, the details required and what people could expect in terms of responses and time scales. The policy also gave the details of the local authority, Care Quality Commission and Local Government Ombudsman. The provider had responded to any complaints in accordance with their policy. Only one concern had been received since April 2016, relating to the lack of a physiotherapist in the unit. The provider had made several attempts to recruit a physiotherapist but had been unsuccessful.

A residents and relatives meeting was held on 13 February 2017, although this had been the first one for some time due to the absence of the registered manager. The unit manager did say however that they were always around the service, chatting to people, so people raised issues with her as they experienced them. At the meeting held on 13 February 2017 people and their relatives raised a number of issues that were answered there and then. For example one person said the food was not 'always great' and the unit manager said they would ask the chef to speak directly to the person to find out what they liked and what they did not like. Thank you to the staff was expressed by some of the people attending.

The unit manager or registered manager undertook a regular audit of care which included asking people about their care. They asked questions such as, 'On a day to day basis do you feel safe living in the home?' 'Are you supported with choices?', and 'Are the staff respectful?'. People's answers fed in to the overall score of findings of the audit in order to drive improvement. People, their relatives and friends were asked to complete questionnaires about the service whenever they wished via an electronic tablet device that was available at all times. For example, questions such as' 'Did your relative appear well cared for today?' 'Do you feel your relative is safe within the care home?' and 'Did your relative like the food that was provided today?'. The results of questionnaires were automatically sent electronically to the provider's head office where the results were analysed and used to develop a plan to make improvements to the service

Good

Is the service well-led?

Our findings

The management team knew people well and were able to talk about their care and support needs as well as what was important to them. One person said, "It's pretty well managed".

The registered manager was absent from the service and had been for some months. The provider had made sure a temporary replacement manager was in place to provide the continued management and smooth running of the service. The manager was supported to manage the Peter Gidney Neurological Care Centre and one other service within the same grounds by a deputy manager. A unit manager was in place to ensure the day to day running of this service.

The provider had systems in place to support the management team. As well as having the opportunity to take part in regular one to one supervision with their line manager, the manager attended managers meetings, organised by the provider, to support and update their managers across the region. The manager attended these meetings regularly and said they found them to be supportive and informative, assisting their performance and knowledge. Management team meetings were held within the home, shared with the provider's other service within the grounds, to ensure the communication and management oversight of the service was maintained.

The provider had a range of audit and monitoring systems in place to check the quality and safety of the service. A 'daily walkabout' around the service was undertaken by various members of the management team and recorded on the provider's electronic system. Where concerns were noted these were recorded and actioned. For example, one daily walkabout identified that some areas were not clean and tidy as a trolley was left in the corridor, hoists and clutter were left in a bathroom and odours were present. These areas were recorded as having been addressed. An audit of people's care was undertaken every month by the registered manager/temporary manager or unit manager. A sample of care plans were scrutinised, the findings recorded and an action plan in place to address any areas that required improvement. The other areas monitored every month within the auditing process included, housekeeping, home governance and information governance. Areas had been identified for improvement and recorded. For example, it was noted that the staff meeting had not discussed recurring themes identified for improvement through feedback received. In addition to the monitoring and audits undertaken by the service management team, the provider's regional manager carried out an independent audit each month to check the management team were adhering to the provider's monitoring systems. The findings of all audits were electronically recorded and the results sent straight to the provider's head office where they were analysed and checked by senior management.

The provider monitored accidents and incidents and complaints received on a monthly basis to check how they were handled, the action taken and to identify areas for improvement where necessary.

Due to the absence of the registered manager, staff meetings had been less regular, however staff told us they felt well supported and could speak to any member of the management team whenever they needed to. The last meeting was held on 25 January 2017 where many items around team working and task

allocation were discussed. Staff told us they were very happy in their role and felt the interaction with the whole management team was very good. Staff were asked their views throughout the year by accessing the electronic tablet device to do this when they wished. The majority of feedback through this system was positive with staff stating they felt part of a team, they trusted their manager and knew what their role was and how they contributed to success. Staff told us that since the change in the management team across the two services they had seen a marked difference and improvement, with changes being made and accepted by staff.

Visiting professionals were invited to give feedback via the electronic tablet device when they were leaving, to record their observations during their visit. The majority of responses received were positive about the care given to people at the service. For instance, 93% answered 'Yes' to the question, 'Were the senior staff professional and knowledgeable today?' and 93% answered 'Yes' to the question, 'Were the staff welcoming during your visit today?'