Sanctuary Care Limited

Arbury Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 31 July 2018 and the inspection was unannounced. The inspection was carried out by one inspector, an assistant inspector and a specialist advisor. A specialist advisor is someone who has current up to date practice in a specific area. The specialist advisor who supported this inspection visit had experience and knowledge in nursing care.

The local Clinical Commissioning Group (CCG) commissioned Arbury Lodge, on behalf of George Eliot Hospital, from Sanctuary Care Limited as a short- stay nursing service located within George Eliot Hospital. Arbury Lodge opened in 2016, the service continues to be operated by Sanctuary Care Limited, who are a large provider of care services.

Arbury Lodge provides accommodation with personal and nursing care for up to 16 adults. All 16 beds, funded by George Eliot Hospital, are for in-patients who have been assessed as 'medically optimised.' This means people admitted to Arbury Lodge are 'medically stable' but need an additional short-stay to assess their future care and support needs. The average length of short-stay at Arbury Lodge is six weeks, and assessments include whether people require ongoing support care packages and for some people end of life care is required.

At the time of this inspection, 13 people were receiving a short-stay placement at Arbury Lodge, with a further two admissions during the day of our inspection.

A requirement of the services' registration with us is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager registered with us for this location, at the time of our inspection visit. However, they had applied to us to de-register because they had changed their role within Sanctuary Care. A new manager was in post at Arbury Lodge and, at the time of our inspection visit, was in the process of applying to become registered with us.

We last inspected this service on 4 May 2017 and gave an overall rating of Requires Improvement. At this inspection we found the provider continued to provide a caring, effective, and responsive service and improvements had been made to how well led the service was. Some further improvements were required to ensure the service was consistently safe. We gave an overall rating of Good.

There were sufficient trained staff on shift who had, overall, been recruited in a safe way so as to ensure people were not placed at risk of abuse, harm or injury. The provider had not, however, always undertaken a risk assessment as a part of their recruitment process when needed.

Risks management plans were in place and actions described for staff to take so that risks of harm or injury

were mitigated. However, actions to mitigate risks were not consistently followed by staff. This posed risks to some people of potential harm or injury.

Medicines were stored and handled safely. People had their prescribed medicines available to them. Some medicine recording errors had occurred and timely action had not always taken to address these with nursing staff. Further improvements were planned for by the manager to address such delays.

Staff on shift met people's individual needs. Staff worked closely with George Eliot Hospital healthcare professionals in meeting people's nursing, health and rehabilitation care needs.

Staff received training and, overall, used their skills, knowledge and experience to provide safe, effective and responsive care to people.

The manager and provider had systems in place to monitor the quality of the service people received. The manager had plans in place to make continued improvements.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Management plans were in place to protect people from the risks of harm or injury from identified risks and safety equipment was available. However, staff did not consistently ensure this was used in line with people's risk assessments. Risk assessments were not always undertaken when needed as a part of the provider's recruitment process to ensure staff were suitable to work with people.

There were sufficient and suitably qualified and trained staff on shift. People had their prescribed medicines available to them and were protected against the risks of abuse.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service was well led.

Systems and processes were in place to check the safety of the service was effective. Further improvements were planned to be implemented.

People were happy with the service they received.

Arbury Lodge

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 comprehensive inspection took place on 31 July2018 and was unannounced. Opportunity for people, relatives and staff to give us feedback following our visit, was given by us leaving a poster displayed in the home about our inspection. One inspector, an assistant inspector and a specialist advisor undertook the inspection. The specialist advisor who supported this inspection visit had experience and knowledge in nursing care.

A completed Provider Information Return (PIR) was returned to us, as requested, during March 2018. This is information that we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, during our inspection visit, we gave the provider the opportunity to give some key information about the service, what the service does well and improvements they planned to make.

We spent time with people and observing communal areas where people interacted with staff. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During the inspection we spoke with 10 people at the service. We spoke with two care staff, the activities co-ordinator, one nurse, the clinical lead nurse, the manager, the quality support manager. We also spoke with two healthcare professionals who were visiting the service. Following our inspection visit, we spoke with the regional manager.

We reviewed three people's care plans, daily records and medicine administration records. This was so we could see how their care and support was planned and delivered. We also looked at other records, these included three staff recruitment files and supervision records, and the provider's quality assurance audits. This was so we could see how the manager and provider assured themselves people received a safe and

well led, quality service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in May 2017, we found the service people received was not consistently Safe. We had found staffing levels were not determined by people's needs and there were insufficient staff on shift. Risks to people's wellbeing had not always been identified. Medicines were not always managed or handled safely. We rated the safety of the service as 'Requires Improvement.' At this inspection, we looked to see whether improvements had been made.

At this inspection we found some improvements had been made in relation to staffing levels and the safe handling of medicines. However, we found some areas that related to the safety of the service provided to people, still required improvement. Therefore, the rating for the safety of the service remains 'Requires Improvement.'

People told us they felt safe from the risks of abuse while receiving a short-stay at the service. Staff understood the importance of reporting any concerns they had and the manager knew what information they had to escalate to us and the local Clinical Commissioning Group (CCG). Safeguarding incidents were reported and investigated.

The provider had a safe system of recruiting staff, and in staff files we looked at, checks including references and nurse's fitness to practice, had been undertaken. However, we found one example where recruitment and management staff had not always followed their system and undertaken a risk assessment to ensure staff were suitable to work with people. We acknowledged additional information shown to us that had been sought by the provider to support this staff's employment application. However, both the manager and quality support manager, agreed a risk assessment should have been undertaken by the previous manager. Following our inspection, the regional manager assured us they had escalated the issue, at provider level, and actions were being taken to reiterate responsibilities under the provider's recruitment process. The regional manager told us they had taken this action so that learning could take place.

Following our previous inspection in May 2017, improvements had been made to ensure there were sufficient staff on shift to meet people's needs and provide effective care. The manager told, "Today, staffing levels are enough, though things can change quickly here, with the short-stay admissions. I would not need prior authorisation if I needed to increase staffing levels urgently to meet people's needs."

Risks of harm or injury to people were assessed. On discharge from George Eliot Hospital to Arbury Lodge, identified risks to people were shared with the Clinical Lead Nurse based at Arbury Lodge. This included any known risks of choking, falls or skin becoming sore. The manager told us that within 24 hours of admission, risk management plans were written for people.

Some people had been assessed as requiring special equipment to reduce risks of injury. These items included the use of a 'crash mat' placed alongside their bed and a 'senor mat' next to their bed, which triggered when stepped on and alerted staff that the person required assistance. We found most people had their equipment in place. However, we found one person's 'crash mat' and 'sensor mat' underneath their

bed and this person was alone in their bedroom and lying on their bed. This person's assessment of risk stated their 'crash mat' and sensor mat should be in place, alongside their bed, unless staff or visitors were with them in their bedroom. Records showed this person had previously sustained two falls and remained 'at risk' of falls. Staff's omission to ensure the equipment was left in accordance with this person's needs, placed them at risk of harm.

Some people were identified as being at 'high risk' of developing sore skin and one person had developed an area of damaged skin during their short-stay. We found where damage had occurred to a person's skin, nurses recorded checks they made of a person's skin to monitor for improvement or any deterioration.

However, where people's skin was intact but they had been identified at 'high risk' of developing sore skin, actions for staff to take to reduce identified risks of damage were not described in management plans. The lack of detail meant staff could not refer to agreed actions to ensure a consistent approach was taken to minimising risks. One person's care record described them at 'high risk' of developing sore skin and whilst nursing staff told us this person's skin was intact, no checks of their skin had been recorded.

The manager told us the service did not currently have a named lead-nurse for skin care, although one nurse had recently started to attend the quarterly tissue-viability (skin) care meetings at George Eliot Hospital. The manager confirmed this nurse would be taking on the lead-role. The manager said part of the role would include cascading knowledge promoting skin care and ensuring nurses documented their checks on people's skin in care records.

Medicines were stored, managed and given to people safely and in accordance with best practice. When people were admitted to Arbury Lodge, they each brought a supply of their prescribed medicines with them from the George Eliot Hospital pharmacy. The manager told us if people required more medicine stock during their short-stay at Arbury Lodge, staff would request this on people's behalf from their GP.

Where medicines were prescribed on an 'as required' basis, detailed information was in place to guide staff in what circumstances they should be given.

Medicines administration records (MAR) were checked every night by nursing staff to ensure any recording errors were identified quickly. Whilst the checks effectively identified gaps in signatures on MARs or gaps where codes had not been recorded, timely action was not always taken to address these errors. For example, no action had been recorded for recording errors that had been identified on 4 and 6 July 2018.

We found the MAR checks undertaken had not led to any improvement being made in the reduction of recording errors made because the number or recording errors remained high. For example, for July 2018, there were 29 incidents of recording errors; gaps in signatures or no reason given as to why a medicine was not given. We discussed this with the manager who told us this would be an area in which they wished to make improvements.

There was a fire alarm system in place and people had Personal Emergency Evacuation Plans (PEEPS) which informed staff, and emergency services, of the level of support people would need in the event of an emergency.

All areas were clean and tidy and cleaning schedules for housekeeping staff ensured the home was regularly cleaned, bedrooms received a deep clean between admissions. Staff had received training so they understood the importance of good hygiene and safe infection control measures, such as using personal protective equipment where necessary.

The provider had a process for ensuring lessons were learned when things went wrong. Staff understood their responsibility to report and record any accidents and incidents. The manager reviewed reported incidents before they were sent to the provider to ensure any learning was identified. The manager gave us an example of such learning from a previous incident, and described when they would request a person's plaster-cast to be reviewed by George Eliot Hospital team; if they had concerns about a person's skin integrity under their plaster-cast.

Good

Is the service effective?

Our findings

At this inspection, we found staff had the same level of skill, experience and support to enable them to meet people's needs as effectively as we found at the previous inspection visit. Staff continued to offer people choices and supported them with their dietary and health needs. The rating continues to be Good.

Staff felt they had the knowledge and skills they needed for their job role. All new care and nursing staff completed the provider's induction training, this included self-guided on-line training sessions, taught face to face sessions and working alongside more experienced staff (shadowing). For care staff new to working in the care sector, their induction was linked to the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high- quality care and support. Care staff who had previously completed a nationally recognised vocational qualification in health and social care were not required to complete the care certificate and their practices were assessed during their probationary period. Care and nursing staff received on-going updates to refresh their skills and knowledge.

Monitoring of people's fluid and food intake took place. During the first week of all people's short-stay at the service, they had their fluid and food intake monitored by all staff. These records were then reviewed by nursing staff to determine whether individuals were at risk of dehydration or malnutrition. Where there was no risk identified because fluid and food intake was sufficient, monitoring ceased until a person's needs changed.

People's nutritional needs were met. People told us they were offered choices of food before each meal. One person told us, "Staff come around before each meal and ask you what you want." Another person said, "Staff offer me a choice before each meal and if I don't like it they will offer me something else. There is usually a choice of two or three options." People had a choice of where they ate their meals. One person told us, "I can go to the dining room but I like to stay in my room." The dining room lunchtime experience was relaxed for people with staff support available if needed. People spoke positivity about the food within the home. One person told us, "The food in general tastes nice". Another person told us, "The food is pretty good".

Access to healthcare services was maintained so people's individual needs were met. Prior to their admission to the service, people were assessed as 'medically stable' by healthcare professionals at George Eliot Hospital. However, people had on-going nursing, rehabilitation and care and support needs during their short stay. People's health needs were part of the daily staff shift handover, with written records detailing who had specific healthcare appointments to attend. On the day of our inspection visit, these included visits to the George Eliot Hospital x-ray department, scans and orthopaedic consultant appointments.

Nursing staff at the service worked closely with hospital departments to supply swab samples for people when needed so that infections could be checked for. The hospital phlebotomist visited the service to take blood samples from people when needed. GP visits took place at the service three days a week, however, if

someone needed a doctor outside of the planned visits, nursing staff told us this would be arranged.

A hospital social worker allocated to the service told us, "Things are going well at Arbury Lodge, I've no concerns." The social worker worked with people, their relatives, staff and other healthcare professionals to plan discharges and packages of care that some people may require to be in place before they went home. They also supplied some people with information about long-stay care homes if a greater level of on-going care and support was needed.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

As a part of the assessments of people prior to their admission to Arbury Lodge, the manager or clinical lead nurse included a question about whether a person had capacity to make their own decisions or not. Where people lacked the capacity to make a decision for themselves about receiving a short-stay at Arbury Lodge, their relatives were involved in this decision and 'consent' records showed this.

At the time of our inspection visit, everyone receiving a short-stay at the service had mental capacity and was able to make their own decisions. The manager understood their responsibilities under the Mental Capacity Act and gave us examples of when they would apply to the supervisory body for a DoLS. Staff gave people choices and understood the importance of gaining people's consent before, for example, supporting them with personal care. Staff understood that when people may not be able to make simple choices, they must act in the person's best interests based on their knowledge of people's likes and dislikes.

The premises were previously a ward within George Eliot Hospital and had been refurbished at the time the service opened in 2016. The service was ground floor, with 16 individual bedrooms with shared toilet, shower and bathroom facilities. Wide corridors gave easy access to the communal dining room and lounge. There was a small courtyard garden which people could freely access. The manager told us one person's family had recently given the garden a 'make-over' and this, along with a local student group who had painted a wall-mural, created a pleasant space where people could relax and enjoy the fresh air.

Good

Is the service caring?

Our findings

People received the same level of kind care and support as at our previous inspection. The rating continues to be Good.

Staff were patient with people and provided support without rushing. People responded positively to staff and appeared comfortable with them. One person told us, "Where they find these young ladies (staff) from I don't know but they are brilliant. That's the honest truth." Another person said, "The staff are friendly. We have a little chat. They have time to talk to me."

Staff did not know the people they cared for well because it was a short-stay service. Care plans contained important information about people's physical needs, though did not contain information which might enable staff to talk with them about interests and hobbies supporting their emotional wellbeing. We discussed this with the manager who thought the introduction of a basic 'person pen-portrait' might be useful in this type of service. The manager told us they would discuss ideas further with staff as a planned improvement, so as to promote staff knowing people as much as possible during their short stay.

Staff told us they were informed about people's communication needs at each handover to ensure they had up to date information about people. The written shift staff handover detailed, for example, that staff should ensure one person was supported to wear their hearing aides so communication was effective for them.

People were supported to maintain important relationships to them. Staff told there were no set 'visiting hours' and people's relatives and friends were able to visit without restriction. One person told us, "My husband is in hospital next door and he can't get to visit me here. The girls (staff) here take me up to see him whenever I want." Where people were unable to attend special family events due to their frailty and / or short stay at the service, staff made efforts to ensure occasions were celebrated. For example, one person had been unable to attend their grand-daughter's wedding so staff enabled a celebration to take place at the service where relatives visited wearing their wedding outfits and a special photograph marked the occasion.

Staff received training in diversity, equality and inclusion and demonstrated a good understanding about treating people as individuals. They gave people choices and ensured their preferences were respected. For example, staff asked people if they wanted their bedroom door left open during the daytime, which most people did, whilst they were in bed, so they could see out into the corridor.

People told us that staff had a caring approach and encouraged their independence. One person told us, "I do as much as I can and staff will just help with the bits that I can't do". Another person said, "Staff encourage me to do as much as I can for myself".

People told us staff maintained their dignity. One person said, "I never feel embarrassed. Staff have to apply my cream to my body and they are delicate". On the day of our inspection visit, we observed a staff member supporting a person to pull their nightdress down at the back as the person was worried that they were

exposing themselves.

Good

Is the service responsive?

Our findings

At this inspection, we found people continued to receive care that was responsive to people's needs during their short-stay at the service. The rating continues to be Good.

People made positive comments to us about their short stay at the service. One person told us, "All of the staff are lovely. They will help me with anything I want." Another person said, "The staff here are so good. Nothing is too much trouble for them."

Important information about people at the service was shared with staff at the beginning of every shift. Written handover information contained a brief, though detailed, profile of each person's past medical history, health conditions, moving and handing support needs and other important information. Staff told us this kept them up to date with who was currently receiving a short stay at the service and their changing needs.

People had individual care plans in place within 24 hours of their admission to Arbury Lodge from a ward at George Eliot Hospital. Initial care plans focused on people's physical care and support needs and minimising risks of harm or injury to them. The manager told us a more detailed care plan was written by nurses within seven days of admission. The manager said that where possible, people and their relatives were involved in sharing information about preferences and choices and this was included in people's care plan. For example, one person told us they had requested female staff only to support them with personal care and this person confirmed this had been followed.

On the day of our inspection visit, the service did not support anyone who was in receipt of end of life care. The manager told us more recent referrals to them from George Eliot Hospital were of an orthopaedic nature, and on the day of our visit they were supporting people with rehabilitation. However, the manager confirmed end of life care was available if such referrals were made for people who were medically stable for discharge to a setting such as Arbury Lodge where they were able to offer the necessary level of care.

Some people felt some of their rehabilitation needs were not currently being met. One person told us they had been unable to access any physiotherapy input over the past two weeks. Another person told us, "My only grumble is that I haven't seen a physio and I don't know what I am supposed to be doing."

Physiotherapists employed by George Eliot Hospital provided rehabilitation support and guidance to people referred to them, during their stay at Arbury Lodge. On the day of our inspection visit a physiotherapist visited the service and did see various people, including the person who had waited two weeks. We discussed the delays in referral responses to some people receiving physiotherapy input with the visiting physiotherapist and the manager. The physiotherapist told us, "It has been haphazard since the allocated physio for this service went on planned leave a few weeks ago. Arbury Lodge is supposed to receive around 18 hours of physiotherapy each week." We were told the physiotherapy input had declined to 'about three hours" a week over the past few weeks.

The manager assured us they had taken measures to address this within the Multi-Disciplinary Team meetings. The manager had raised concerns themselves about the lack of responsiveness in meeting people's rehabilitation needs through physiotherapy input. We were assured by the manager and George Eliot Hospital physiotherapist, that a locum physiotherapist would be starting on the Monday after our inspection and that interviews for permanent cover were taking place during August 2018. On the day of our inspection visit, everyone who had raised issues with us about their lack of physiotherapy support, to date, did receive some input.

People were supported to engage in social activities and maintain their hobbies during their short stay. Some people joined in a musical 'sing-along' in the communal lounge area, people smiled and we heard them join in with songs. Another person spent time enjoying the sunshine and reading in the garden. Most people chose to spend time in their bedrooms, one person showed us their knitting and told us, "I'm happy enough in my room, I keep the door open so I can see what's going on. I have a walk with staff every so often." A few people felt too frail to engage in social activities and wanted to rest on their bed. Staff checked on people in their bedrooms to ask if they needed anything.

People told us they would speak with staff if they needed to complain about anything. The provider had received two complaints to date during 2018. The manager showed us copies of the investigations that had taken place and actions that had been taken in response to issues raised.

During our inspection visit, one person raised a concern with us about an incident that had occurred at the service. After speaking with us, this person discussed the issue with the manager. The manager and quality support manager assured us they would follow the provider's policy to investigate the issue raised further. Following our inspection visit, the regional manager confirmed investigations were taking place in line with the provider's procedures.

Good

Is the service well-led?

Our findings

At our previous inspection in May 2017, we found the service was not consistently well led. We had found quality monitoring of the service took place, however identified needs for improvements did not always take place or had not always been sustained. We rated the how well led the service was as 'Requires Improvement.'

At this inspection, we found improvements had been made, and further improvements were planned for by the new manager. We gave a rating of 'Good'.

At the beginning of our inspection visit, we were told about some management staffing changes at the service. The previous registered manager had changed their role within the organisation and was in the process of de-registering with us. The new manager had commenced their role during July 2018 and was being supported three days a week by a new quality support manager. The manager told us they felt 'very well supported in their new role' by the quality support manager. Both told us they felt improvements to the service had been made. The manager gave us examples of some areas that were 'work in-progress,' such as the further development of the activities co-ordinator's role. The manager and quality support manager told us about their further planned audits, which included staff files. This was part of the quality support manager's role in providing guidance for the new manager in undertaking audits.

Staff told us they enjoyed working at the service, one told us, "I love it here" and another staff member said, "It's marvellous here." Staff felt supported by one another within their team and by the manager, who was described to us as 'approachable' and 'willing to listen.'

People receiving a short-stay at the service were not able to tell us who the manager was, though when we accompanied the manager to look around the service, people recognised them and felt at ease to talk with the manager. One person told us, "I don't know who the manager is, there are that many staff that come in to see me." There was a 'who's who' staff photo display board in the reception area of the service for relatives and visitors to refer to. The manager told us consideration would be given to duplicating this in a more accessible area to people, so they could also put a name to staff members.

Staff felt supported in their role through training, one to one supervision meetings and team meetings. Changes took place following suggestions and discussion in team meetings. For example, the April 2018 team meeting had suggested a change as to how staff shift handover took place and this was successfully implemented. Being new in post, the manager had not yet led team meetings or implemented actions that may arise, though told us this was planned for August 2018.

The manager, quality support manager and regional manager considered ways of improving outcomes for people who received a short-stay at the service. Following our previous inspection, more rigorous checks had been implemented on fluid and food recording charts. The manager told us 'purple file' audit checks were completed by them on a weekly basis. They showed us examples of these, what information they looked for and actions they would take if information was missed.

Following our discussions, on this inspection visit, with the manager about the lack of people's skin checks being recorded, immediate action was taken to implement this as a weekly check by the manager. The regional manager shared information with us which showed this check as being a part of people's individual bedroom 'purple file' recordings.

There was a quality assurance system to ensure people received a safe, effective and responsive standard of care. The provider monitored the service through a series of checks and audits and improvement plans were implemented when actions needed to be taken. For example, to reduce medication recording errors.

We looked at fire safety and found people were protected from the risks of fire. However, we saw a 'fault' light showing on the service's fire alarm indicating panel and discussed this with the manager. They confirmed they were aware of 'fault' showing and told us this had been showing since 2017, they added that the previous manager had escalated this issue to the responsible personnel within George Eliot Hospital. George Eliot Hospital maintained Arbury Lodge's fire alarm system because they owned the premises. The manager told us they themselves had been verbally assured by the responsible personnel that the fire alarm system was fully functional, however, it continued to show 'fault.' The explanation given was that the fire alarm panel within Arbury Lodge interfaced into the George Eliot Hospital's main fire alarm and a 'fault' anywhere within the Hospital premises would show on Arbury Lodge's panel. We asked the manager to address this, on the provider's behalf, with George Eliot Hospital maintenance during our inspection visit which they did. A visit from George Eliot Hospital maintenance took place and rectified the issue before the end of our inspection visit, which meant the fire panel no longer warned of a 'fault' in the system.

The manager told us they used the provider's daily checklist document to support their daily 'walkabout' the service. The manager gave us examples of issues they had identified over the past few weeks, since they had come into post, and when they had spoken with staff to improve practices. However, these were not documented which meant the manager was not able to refer back to speaking with staff members if the same issues re-occurred. Issues we identified while looking around the service, had not been identified by the manager's earlier walkabout. However, when we pointed out issues that included one person's safety equipment not being next to them, another person's table positioned so they found it difficult to reach their hot cup of tea and a staff member's cigarette lighter which had been left unattended, they were immediately addressed by the manager.

The manager and quality support manager had undertaken a medicine audit during July 2018 and found a 90% compliance with the provider's policy. The manager told us some improvements had been made to the safe handling and administration of medicines and further improvements were planned for. These included timely action being taken in relation to checks identifying signature gaps and codes not been entered on people's medicine administration records (MARs). The manager and quality support manager agreed there had been a lack of timely action taken and shared with us their improvement plan which stated 'gaps on MARs would be addressed within 24 hours with staff,' this was due to be implemented from August 2018.

People were encouraged to share their views and provide feedback about the service. As a part of each admission, people and / or their relatives were given a feedback form which they could complete at any time during their short-stay or following their discharge. Due to the short-stay nature of the service, the manager had recognised that the traditional annual questionnaire about the quality of care within the service, was not the most effective way of capturing peoples' views. Plans were in place to start to evaluate feedback forms on a quarterly basis for the service from August 2018. The manager told us this would enable more frequent analysis and improvements to be made, if needed, in a more responsive way to people's feedback.

The manager worked in partnership with other healthcare professionals within George Eliot Hospital and

the local clinical commissioning group (CCG). The manager told us current referrals from the hospital were now largely orthopaedic. We found some staff did not have detailed knowledge on supporting people with plaster-casts on limbs and discussed this with the manager and quality support manager. The regional manager informed us they had spoken with the George Eliot Hospital Physiotherapy department who had agreed to provide specific person-centred information to staff to ensure staff's knowledge of people's individual needs were fully understood.

The provider had notified us of events that occurred at the service as required, and had also liaised with CCG commissioners to ensure they shared important information in order to better support people.

It is a legal requirement that the provider's latest CQC inspection report rating is displayed at the service. This is so people, visitors and those seeking information about the service can be informed of our judgements. The provider had clearly displayed the rating in the entrance reception area of the service and on their website.