Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

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Date of inspection visit:
14 December 2016
15 December 2016

Date of publication:
10 February 2017

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 and 15 December 2016 and was unannounced. The Dean Neurological Centre provides accommodation for 60 people who require personal care with nursing. There were 53 people living in the centre at the time of our inspection. The centre provides personal care and support to people with complex long term neurological conditions, brain or spinal injuries and requires on-going support and assistance to maximise functional ability.

The centre is purpose built and set over two floors, each floor comprising 30 individual bedrooms, communal lounges and dining rooms. On the ground floor there is therapy department and people have access to several decked areas in the garden.

There was registered manager in place as required by their conditions of registration. 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.

People and their relatives were mainly positive about the care they received however we found people's safety and well-being was compromised in a number of areas.

There were inconsistencies in the detail and information in people's care records. Information was not always accessible or consistently recorded to provide staff with guidance. There was an irregular approach to the monitoring of people's risks and well-being. There was limited evidence that people's mental and social well-being had been addressed. Staff supported people who lacked mental capacity in their best interest and knew their preferences well; however assessments of people's mental capacity had not been consistently carried out. Protocols were not in place for people who required their medicines 'as required'.

Staff were confident in their role and said they felt trained and supported. However their skills and care practices had not been continuously checked or updated. Staff had not received regular private support meetings to discuss their development and performance.

People were supported by staff who were kind and compassionate and knew people well. Staff interactions

were positive and caring. They respected people's dignity and privacy when supporting people with their personal care. Staff understood their responsibility to safeguard people and report any concerns.

People enjoyed the meals provided. Those who had specific dietary needs were catered for. People's medicines were mainly managed well, although accurate stock levels of medicines were not always kept. People were supported to access a variety of health care services as required.
The centre was adequately maintained and clean. Staff demonstrated good infection control practices.

The manager dealt with any issues from people and their families on a day to day basis and had acted on people's concerns. Their views were sought but not always acted on. Systems to monitor and improve the quality of service people received and the training of staff were in place. However these systems were not effective in driving improvements within the service. The registered manager and provider were aware of concerns found during this inspection, and were formulating actions to improve the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this report.

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 always safe.

Records of effective monitoring and management of people's risks was not always in place.

People's medicines were mainly managed well, although protocols were not in place for people who required their medicines 'as required'. Accurate stock levels of people's medicines were not always kept.

There were sufficient numbers of staff to meet people's needs. Suitable systems to check the employment history of new staff were in place.

The centre was well maintained and clean.

Staff were knowledgeable about reporting any safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst staff felt they were well trained and supported; their training and knowledge was not regularly monitored and checked. Staff had not received regular private support meetings to discuss their development and performance.

Assessments of people's mental capacity were not consistently been carried out. Staff supported people in their best interest.

People's dietary needs and choices were catered for. People were supported to access health care services as required.

Is the service caring?

Good

The service was caring.

Staff interactions were positive and caring.

People and their relatives were positive about the staff who cared for them.

Staff respected people's dignity and privacy when supporting them with their personal care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care records did not always provide staff with the information they needed to support people. There was limited recorded evidence that people's well-being around their individual social and recreational needs had been addressed.

The manager dealt with any issues from people and their families on a day to day basis and had acted on people's concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider and registered manager had systems which assessed and monitored the quality of service people received and the training of staff. However these systems were not always effective in driving improvements within the service.

People and their relative's views were sought, however there was not always clear evidence that negative comments or views had been acted upon to improve the quality of the service.

The registered manager and provider were aware of concerns found during this inspection, and were formulating actions to improve the service.

The Dean Neurological 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 14 and 15 December 2016 and was unannounced. The inspection team consisted of two inspectors, an inspection manager and a specialist advisor.

Before the inspection the provider completed 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 also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the centre and observing how staff interacted with people. We spoke with four people and four people's relatives and visitors. We looked at eleven people's care plans and associated records and pathway tracked the care and support of seven people.

We also spoke with eight care staff and five nurses as well as kitchen and maintenance staff, the training coordinator, the activities coordinator, the registered manager and representatives from the provider. We looked at recruitment procedures and the training and development of all staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the centre.

Requires Improvement

Our findings

People's risks were largely being managed well by staff who were knowledgeable about people's individual risks. We observed staff were relatively knowledgeable in the care and support they provided to people. For example, staff performed safe practices when assisting people with their tracheostomy and ventilator (a medical procedure to assist people with their breathing) and were aware of the actions to be taken in an emergency. Adequate monitoring and safeguards were in place for people who were at risk of disconnection from the ventilator or at risk of their tracheostomy blocking or being dislodged. Staff observed and monitored people's welfare from outside their bedrooms when not directly caring for them. However, records of people's risk assessments and management plans were not always adequately detailed to provide staff with the guidance they needed to care for people in a safe manner. For example, there were limited recorded details for how staff should support people when they had been assessed as being at risk of pressure sores. Other people required their nutrition and fluids via a type of feeding tube called a percutaneous endoscopic gastrostomy (PEG) to ensure they received adequate nutrition and fluids; however there was limited information to advise staff on how to manage people's feeding regime, PEG sites and associated equipment. We found staff had not consistently recorded when they had supported people with their PEG needs. Health care professionals shared with us their concerns about the management of people's PEGs and felt these practices had resulted in some people being admitted in to hospital unnecessarily. One healthcare professional felt people's psychological needs were not being effectively managed. We found that there was insufficient information in place to inform staff how they should support people's individual mental well-being. We found some people's risks were not being assessed and monitored as needed. For example, some people had been assessed as at risk of weight loss. Their care plans recommended they should be weighed monthly however records indicated this was not always undertaken.

The management and records of people's risks were not consistently maintained. This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were also at risk of not receiving some medicines which were prescribed as 'as requires' such as medicine used to calm people's anxieties, because there were not always clear written protocols in place for nursing staff to follow. For example, two people had 'as required' medicines which were used to control behaviours. Both people received their prescribed medicines frequently; however there was no record of why they had needed these medicines, or when these medicines should be administered. There was a risk that people may be receiving medicines which they did not require in the first instance. Where people required pain relief medicine 'as required' there was not always clear protocols for staff to follow to ensure

people received these medicines to effectively manage their pain relief.

Clear protocols were not always in place for people who were prescribed 'as required' medicines such as medicines for pain relief. There was no record of the reasons why people had been given these medicines or if alternative strategies had been tried. Nursing staff did not always keep an accurate record of the stock of people's prescribed medicines and did not always date when people's prescribed medicine boxes had been opened. Medicine fridge temperatures were recorded; however the medicine room temperatures were not consistently recorded. A concern was raised with us about the management of people's medicines via their PEG tube. We followed up on this concern and found that people who required their medicines via their PEG tube were given their medicines appropriately.

We recommend that the service considers current guidance on the management of people's medicines from a reputable source.

People's prescribed medicines were kept secure. The registered manager had links with the pharmacists connected with the centre and the GP surgery to ensure the communication regarding the ordering and delivering of people's medicines was safe and effective. We were told that the pharmacist sometimes attended the multidisciplinary team meetings and had helped to review people's medicines.

People could be assured the premises were safe, clean and well maintained. Records showed checks were carried out to ensure the building was maintained and people's equipment was regularly serviced. Maintenance staff ensured contractors were available to check the fire safety and gas safety of the premises. Staff complied with infection control procedures and the environment was maintained, clean and safe. A clear schedule for the cleaning of people's pressure mattresses was in place to safeguard people from the risk of infections. Records showed that staff completed hand hygiene training and their practices were checked to ensure staff effectively prepared, washed and dried their hands to prevent cross contamination. Adequate hand washing facilities, gloves, aprons and alcohol gel were provided and used by staff. We observed staff using safe and clean practices when assisting people with tracheal suction and other invasive procedures such as catheter care. Equipment associated with tracheostomy care and ventilation care were stored and labelled adequately to prevent the risk of cross contamination.

People were supported by sufficient staff to meet their needs. There was a high level of qualified nursing staff and care staff at the centre due to the complexity of people's medical needs as well as an established rehabilitation team. The registered manager shared with us examples of staff rotas on their electronic staff rota system. The system was reviewed daily by the registered manager to ensure there were sufficient staff to support people. We were told that people's admissions were planned in advance to ensure there were adequate staff available to meet their needs. Where there were known shortages in the staffing levels, staff had picked up additional shifts or agency staff had been used. The registered manager shared with us that they had experienced staffing problems earlier in the year but they were currently recruiting new staff to help reduce the need of agency staff. Reports showed that the provider monitored the staff sickness levels and employee turnover. The general manager told us recruiting permanent staff had been one of their biggest challenges in recent months. People told us staffing levels had improved and there were less agency staff supporting them. One person said, "There is always someone around to help if I need some assistance. Sometimes I have to wait a few minutes more when they are busy in the mornings but generally it's OK."

The centre generally followed safe recruitment practices. Records relating to the recruitment of staff showed the majority of relevant checks had been completed before staff worked unsupervised at the centre. We were told the provider intended to change their procedures and carry out further criminal checks on staff every three years. However, we found where staff had completed an online application form; applicants had

not been required to disclose the reason for leaving their previous employment. We raised this with a staff member who was responsible for the recruitment of staff. They told us the provider was in the process of reviewing the recruitment policy and they would reinforce the legal requirement to request this information. In the meantime, questions regarding gaps in the applicant's employment histories and the reason why they had left their previous employers had been added to the interview questions.

People told us they felt safe living at The Dean Neurological Centre. They told us they felt safe amongst staff and were protected against the risks of potential abuse and harm. One person said, "I'm happy here. I feel quite content." Staff had been trained in safeguarding and protecting people and were knowledgeable about their responsibilities for reporting accidents, incidents or concerns. They told us they would immediately report any concerns to their line manager. One staff member said, "I would flag it up straight away. No hesitation." Safe processes were in place to support people who needed assistance to manage and handle their money to ensure they were protected from financial abuse. Information leaflets were available to people, their relatives, visitors and staff which assisted them to recognise the different forms of abuse and how to raise a concern.

We discussed with the registered manager about the management of a recent safeguarding incident. The registered manager had discussed the incident with their line manager and staff and had reflected on the events that had occurred after the first allegation of abuse had been made. They acknowledged that there had been some shortfalls regarding communication with relatives and other health care professionals and services. However, we were reassured that improved communication processes would be put into place such as direct communication with health care professionals when people transferred to other services.

Requires Improvement

Our findings

People were at risk of receiving ineffective care as the systems used to monitor staff training were unreliable and did not always reflect the current status of staff training. For example, the systems showed non-qualified staff and nurses had not always received mandatory training updates in all areas although we were told that most staff had completed their training updates. Nursing staff had received training in specialist subjects such as bowel care, catheter management, syringe driver, tissue viability; however the training dates implied it had been some years since they had completed the training. We were told that some of the clinical training for qualified nurses was optional and therefore not all nurses had received up to date training to refresh their specialised skills. We raised our concerns with the registered manager who provided us with evidence that demonstrated some nurses had attended recent training in subjects such as spinal bowel care, tracheostomy management, incidents and investigation outcomes and oxygen management but this was not evident on the training systems.

The skills and knowledge of staff were not being regularly monitored to ensure people received effective care and support to meet their needs. For example, we found the competencies of staff for the care and management of people's tracheostomy and ventilations and care standards observations were not being consistently checked. There was limited evidence that the nurse's' skills in subjects where they cascaded their knowledge to non-qualified staff was current or up to date. We were told that specialist health care professionals had also provided staff with training in their field; however records showed that the skills of staff were not consistently monitored in line with provider's requirements.

We received various comments from health care professionals about the skills and knowledge of staff. Some health care professionals felt the non-qualified staff were trained to carry out their role. For example one health professional said, "The health care assistants are so well trained; not to qualified level but they are so rapid in their response when emergencies crop up." However other health care professionals spoke to us about the management of people's specific medical needs such as people's PEG and catheter care. Two health care professionals shared with us examples of the poor management of people's medical needs which had required their intervention or hospital admissions.

Staff, however told us they felt skilled and competent to carry out their role. The care standards of staff were observed and monitored twice a year; however records showed that this was not consistently carried out with all staff. An induction programme was in place for all new staff which provided them with training in subjects such as manual handling and safeguarding by in-house accredited trainers. We were concerned about the quantity and quality of the topics being delivered on the induction course. We discussed this with

the training coordinator who delivered some of the training and were told staff received further training once they were established in their role. One new staff member confirmed that they had received a comprehensive induction and had felt confident to carry out their role. The skills of new staff were monitored in line with the standards required for the care certificate. Staff who had a level two qualification in health and social care were not required to undertake the care certificate. They carried out a self-assessment of their care skills and any gaps in their knowledge were addressed with additional training as required. We were told new staff also had the opportunity to shadow more experienced staff for approximately two weeks and their skills were assessed before they became part of the team. However, the records of new staff observations were not consistently recorded in line with the provider's induction procedures.

Where there had been staff shortages, the registered manager had authorised for agency staff to be used. The centre had been provided with profiles of the skills and qualifications of potential available agency staff; however the information about the agency staff had not been kept up to date. Therefore the registered manager was not always assured that people who received care from agency staff had up to date training and employment checks. However, we were told that agency staff never worked alone and they received a brief induction before they worked with people. They were introduced to staff members who provided support and advice during their shift. One staff member explained. "We always take the lead when agency staff are on the shift."

Staff complimented the centre and the support they received from the manager and their colleagues. One staff member said, "This place is awesome to work at. There are plenty of opportunities for training." All the staff we spoke with told us they felt supported in their role. For example, one staff member said, "I can always speak to the clinical staff or a senior member of staff. I feel supported." Another staff member said, "We get a lot of support, the clinical leads and nurses are fabulous towards the red tops (non-qualified staff)." However, records showed not all staff had received regular one to one private meetings in line with the provider's expectations to discuss their performance and development with their line manager.

Whilst we found elements of good training and support of staff this was not always consistent for all staff. Therefore people may potentially be at risk of receiving ineffective care and support as not all staff had received consistent training and support to carry out their roles. Staff skills and competencies were not consistently monitored and recorded. This is a breach of Regulation 18, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some of the training delivered to staff was carried out in-house by experienced staff or staff who had been trained to deliver accredited courses such as challenging behaviour, manual handling, safeguarding and the Mental Capacity Act. Staff were required to carry out a 'Care with confidence course' which provided non-qualified staff with the skills to deliver personal care such as mouth and catheter care. Non-qualified staff were also trained by qualified nurses or therapists to manage people's clinical needs such as PEG management, tracheostomy and respiratory care; dysphasia and communication aids. Staff were also provided with additional training information such as a booklet which provided them with information on how to support people with tracheostomies, ventilations and humidification. Some of the courses which had been arranged were optional and poorly attended.

The training coordinator shared with us the courses and training which had been booked for staff to attend for 2017 such as safeguarding adults at risk, health and safety, manual handling and challenging behaviour. The training needs of the therapy and night staff had also been identified and planned in subjects such as basic life support, infection control combined with hand hygiene. We were told that new and established staff would be given a training record card which will assist staff and their line manager to have an overview

of their training requirements. The therapy lead was also working on standard operating procedures established from evidence based references in areas such as suction and the management of tracheostomy. This would provide staff with current guidelines in the management of people's medical needs. Staff at all levels were encouraged to undertake a national qualification in health and social care and management. The centre had been examined by a local university and had been cleared to take student nurses.

The registered manager was aware that not all staff had received regular private support and development meetings and was in the process of reviewing the format, system and management structure to support staff. Therapists told us they received external clinical supervision which provided them with the opportunity to discuss any concerns relating to their specialist role and ensure their practices were current. Staff told us they felt supported and were confident in the staff they worked with. One staff member said, "We are close knit community here."

Staff had a basic understanding of the principles of the Mental Capacity Act 20015 (MCA). We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty were being met. 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's lawful consent to their care had not always been documented. Some people had the mental capacity to agree and make decisions about the care and support they received. However other people had been assessed as not having mental capacity or had difficulty informing staff of their decisions. Throughout our inspection we found staff communicating with people and informing people of the support they were about to receive or asking their opinion. Their approach was person centred and always in people's best interest if they were unable to express their views. However there was limited recorded evidence that people's mental capacity had been assessed. Records showed that best interest meetings had occurred with people's families and health care professionals when specific decisions had needed to be made. However there were limited records of whether people's mental capacity had been assessed to establish if they could contribute towards the decision making process.

Records of people's mental capacity to make specific decisions about their care and treatment were not always evident. This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We were reassured that people with the lack of mental capacity to make decisions about their short and long term care and support needs were being cared for in their best interests such as planning their long term accommodation and care packages or their end of life care. Records showed that staff had worked with people to highlight possible side effects and consequences when people wanted to make unwise choices about their health care.

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 are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had identified if people were being deprived of their liberty and had applied for authorisation to do this in accordance with DoLS.

People's dietary needs were known by staff. Catering staff, who provided meals for people living at The Dean Neurological Centre, were aware of people's individual needs, such as where people required a pureed diet

or fortification (added calories) to their food. We spoke with the head of catering who informed us that on a weekly basis they received an update of people's dietary needs from the registered manager. They were also informed if anyone's needs had changed or if anyone had been admitted to the centre. They also told us they were informed of when people had lost weight and required their meals to be fortified by using full fat milk, cream and butter for food such as mashed potatoes and soup. The catering team provided two choices at each mealtime and ensured variety was provided throughout the menu.

People generally complimented the meals. They ordered their food a week in advance from a set menu. Most people said they were offered an alternative meal if they didn't like their food choice on the day. For example, one person told us they always requested a jacket potato in the evening which was provided from them. People had the option to attend the breakfast club in the morning and had access to a range of snacks throughout the day. The centre had a servery where staff could make small meals such as toast when requested by people. There was also tea and coffee making facilities available for people, their relatives and visitors to the service. One person told us, "I never go without; I can always have food and drink when I need."

People who could not eat independently received assistance and support from staff. We observed people being supported to eat at lunchtime in the dining room. Staff supported people to eat and drink with patience and dignity. They respected people's pace of eating and volume of each mouthful. People who experienced swallowing difficulties had been assessed by the speech and language therapists. Their recommendations were acted on and documented in people's care plans.

People were supported to maintain their health and well-being and have access to health care services and receive ongoing health care such as attending optician and dentist appointments. The centre received daily visits from their local GP surgery who managed and overviewed people's general medical needs. Records showed people were referred to appropriate health care services when their needs had changed. Staff told us they worked with many health care professionals across a range of services and local authorities to ensure people's present and long term needs were being effectively managed. We received mixed comments from health care professionals who visited the centre. All professionals commented that staff were caring and supportive but some felt that their recommendations were not always adhered to. Their concerns are addressed in "Is the service responsive?" part of this report.

The centre held monthly multi-disciplinary team (MDT) meetings with key staff from the centre and significant external health care professionals to discuss each person's progress and any medical concerns including their physiotherapy and speech and language therapy needs. The MDT discussions and agreed actions were recorded and allocated to a member of staff. These meetings enabled the service to co-ordinate people's care and treatment.

Good

Our findings

People were cared for by staff who were kind and compassionate about supporting people to have a good quality of life. We received comments such as, "The red tops (non-qualified staff) and nurses here are fantastic" and "Yes, I can certainly say I'm well cared for." One person who we spoke with said they had chosen to come to the centre and explained why they enjoyed living at centre and concluded by saying, "The staff here are like my friends."

We observed people being brought into the large communal lounge by staff in the morning. Staff spoke to people in caring manner, using their preferred names as well as establishing eye contact. Throughout the morning staff greeted people in a warm and friendly way, saying good morning to them and asking how they were. It was clear that staff knew people well and people cherished their considerate and sociable approach. People commented that they found the staff were very approachable. Later in the day we observed a game of bingo being carried out in the main lounge. Some people were independent in playing the game, whilst others required assistance. Staff supported people in an inclusive manner ensuring that whilst they may not be able to mark the bingo cards they were part of the game. There was a lot of laughter and meaningful interaction between people and staff. Some relatives also joined in the game.

Some people were unable to interact and communicate with staff due to their medical needs. Staff told us how they spend time with people who were unable to communicate and continued to socially interact with them to ensure they felt inclusive and valued. One staff member said "Whether they can talk to us or not we chat to them and tell them what's happening in the centre or out there" (pointing to outside the window).

People's views and opinions were listened to and respected. Staff asked people where they would like to sit and ensured they were comfortable. For example, we observed one staff member asking a person if they would like their reading glasses on and helped them to set up their lap top. They then offered them coffee and ensured it was within reach before they left them to work on their computer. Other people sat watching TV or chatted with staff and family members around the table. One person told us they thought staff were extremely caring and thoughtful. Another person explained that staff helped them to record their activities, appointments and significant occasions in their dairy to remind them of events. They told us they were supported to maintain their independence levels with activities and tasks associated with their daily living.

People were supported to maintain their dignity. We saw staff being attentive to people's needs such as assisting them with their glasses when their glasses had slipped down their nose or assisting people to wipe their mouths or clothes. One staff member said, "We treat everyone as though they are one of our relatives."

Staff considered people's safety and comfort. For example, a staff member approached a person and enquired about their comfort while sitting in their specialised chair. They assisted the person to adjust their lap belt and confirmed it was comfortable and fit for purpose to ensure the person's safety while relaxing in their chair.

Relatives were generally happy with the nature and attitude of staff who supported their loved one. One relative told us they visited the centre most days and said, "I observe everything, the home is clean and the staff are nice". They explained that staff were very kind to her and they had no concerns". Another relative told us "We can't fault the place. He is always really well looked after. The staff have real affection for the people they care for." Health care professional also commented on the friendly approach of staff. One health care professional told us staff would do anything to help and that 'staff really seem to go the extra mile'.

The centre was well maintained and clean although had a clinical atmosphere due to the complexity of some people's medical needs. We recognised that some people required a lot of medical equipment and therefore it was difficult to create a homely atmosphere. Where possible, people had personal items of interest in their bedrooms. However we found that some people had signs in their bedrooms or attached to their personal equipment reminding staff about important aspects of their care which may have compromised their dignity and privacy.

We recommend that the service seek advice and guidance from a reputable source around ensuring that communication between staff is done in a way that allows people's privacy and dignity to be maintained.

Requires Improvement

Our findings

People did not always receive care that was personalised to their needs or reflected in their care plans. We found there was no standardised approach to the documentation and planning of people's care records which meant staff may have difficulty accessing the information they required about people's care. Parts of people's care records were stored in various files which meant it was difficult for staff to have a holistic overview of people's needs or to assess any trends or early detection of potential deterioration in people's health.

People's care and treatment plans were not always updated to reflect their current needs. Records showed that people's care plans had been reviewed and there was evidence of timely referrals to healthcare professionals as needed. However we found that whilst people's review notes and instruction from health care professionals had been documented, the changes or recommendations were not always embedded in to people's care and management plans. For example, the recommendation from a nutrition nurse about one person's fluid intake had been recorded but not transferred in to their care plans. This meant people's care plans were not always current and did not always give staff sufficient guidance. Some people's care plans had conflicting information in them such as their ability to control their own body temperature or their ability to walk independently. Some documents had not been dated or fully completed such as 'All about me' documents. Staff daily notes or monitoring records were sometimes illegible. The wording used to describe people's wellbeing and medical concerns was inconsistent and therefore may be misinterpreted. We also found there were inconsistencies in the monitoring of people's needs such as fluid charts or chest secretions. People's care plans did not give staff the guidance they required to carry out safe procedures. For example, there were limited guidelines in place for people who required support with their bowel movement. Information about the control of people's bowel including incontinence management was vague.

We reviewed how people's percutaneous endoscopic gastrostomies (PEG) were being managed. People's care plans associated with the management of their PEG was not detailed or kept in their bedrooms to provide staff with accessible information and guidance. We observed staff managing people's PEG feeds. We noted there was regular documented input from the dietician. However, because of inconsistencies in staff documentation it was not possible to assess the home's responsiveness to people's dehydration. Total daily input and outputs of fluids were not consistently recorded, therefore risks of fluid overload or low urine output was not evident. One relative raised concerns with us regarding the management of their family members PEG feed and their daily mouth care. We followed up on their concerns and found a lack of consistent documents to indicate whether the person had received regular mouth care and the actions

taken when the PEG was reported as leaking.

Whilst we found elements of good practice by staff, the details and guidance in people's care records were limited and inconsistent including their care plans, risk assessments, monitoring records. This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

However most people and their relatives felt that staff were caring and responded well to their needs. A relative told us "It's wonderful here. They always involve us". Another relative said "We wouldn't hesitate to raise concerns if we had any but we don't. This place is as good as it gets". Staff were generally knowledgeable about people's risks and contra-indications associated with their medical conditions. Whilst people's care plans did not always provide information required in line with national guidance and standards, we found people were mainly provided with the care they needed. For example, staff had a good knowledge of how to check for pressure areas; competently used equipment for medical purposes or moving people. We observed staff repositioning people and checking them for pressure ulcers. People's tracheostomy sites appeared well cared for. Staff responded promptly when emergency health care needs arose. For example, staff immediately responded at the sound of an alarm.

People were supported by a multidisciplinary team who were mainly responsive to changes in people's needs. The centre had an established rehabilitation team. Within people's agreed contracting care hours people had been funded to have one to one support by staff during parts of the day and could access the therapist team including physiotherapists, occupational therapist and speech and language therapist and their assistants.

Initial assessments of people were carried out by the registered manager and the therapy lead. The outcome of the assessments was shared with the commissioners who predominantly funded the service. Relatives were invited to visit the centre. Some people stayed in the centre for short term with a goal to move back into the community whilst others lived in the centre permanently.

One key staff member felt that some people's goals and rehabilitation needs could be embedded better into people's day to day care. This was also raised by a relative. They explained that some staff did not always consider 'attention to detail' such as making sure their loved one was correctly seated in their chair. Incorrect seating may result in compromising people's skin integrity or breathing. Where possible, people were involved in setting their goals and realistic aspiration. We spoke with the therapy lead who told us their aim was to work towards joint working between the therapy team and the care and nursing staff. They explained they wanted to see a greater development incorporating people's rehabilitation goals within people's daily care and care plans. They described how they were working on improving communication between the departments and educating care staff such as the importance of correct positioning of people in their chairs to prevent clinical incidents. We found that people's rehabilitation goals set with the therapist were documented separately and not threaded into all aspects of people's care.

We spoke with one of the speech and language therapist (SALT) who told us they assessed and reinforced people's SALT goals and outcomes and documented any changes to their recommendations in various sections of people's care records to ensure the changes were communicated well to staff. They told us they spent time ensuring that their recommendations were embedded into day to day practices

The general manager clarified that the provider had a clinical governance team as well as a designated consultant who supported staff with any clinical issues. A neurological consultant provided expert clinical advice and attended the MDT meetings. The consultant felt that The Dean Neurological Centre provided a safe and effective service. They complimented the manager and staff and said, "They were willing to learn

and among the best." The centre also engaged with additional external medical experts to seek additional advice and support.

We received mixed views from health care professionals who were in frequent contact with the centre. Some health care professional wrote to us and informed us that staff worked well with the families of their clients. One health care professional felt the communication from the centre was excellent and that staff were very knowledgeable about people's needs, risks and management plans. However, another health care professional felt that communication from the centre needed to improve to ensure that there was a seamless and informed transfer of people when they needed to move between services. Additionally another health care professional wrote to us and shared with us that they felt people's emotional and psychological well-being was not always managed well. They explained people would benefit from staff who were better trained in behaviour management to ensure there were consistent and effective responses to challenging behaviours. They felt staff training would enhance any recommendations made by specialist health care professions. The registered manager stated that they refer people for psychology input as required but their requests were not always funded.

People enjoyed a variety of activities. The centre employed an activities coordinator to provide activities to people. They told us their working hours were flexible and they often provided activities at the weekend or in the evening. They discussed and planned activities with people for the following week on a Sunday. An apprentice was soon to work alongside the activities coordinator to learn from them and provide them with additional support. We were told the activities - included bingo, quizzes, crafts and trips into the community such a ten pin bowling or outings to a local conservation area. Information about people's personal interests was captured in people's care plans. One relative told us that the service had organised a trip on a steam train for a person's birthday and a member of staff had accompanied them even though they were on their day off. We were told the activities coordinator and staff encouraged people to continue with their personal interests and also provided one to one activities with people in their bedrooms. Staff told us they read and chatted to people with complex needs about their interest. However there was limited recorded evidence of how people's social and recreational needs had been met by staff and how this had benefited their personal well-being.

People and their relatives knew how to make a complaint to the registered manager and provider. People told us their day to day concerns were managed by the staff who supported their needs but knew who to contact if they wanted to make a formal complaint. Most of the relatives we spoke with felt staff and the registered manager were approachable if they had to raise a concern about the care needs of their loved ones. However one relative felt that they had not been listened to. They shared with us a recent incident which compromised their relative's nutrition and fluid intake. They felt the incident had been poorly managed and not acted on. We followed up on their concerns as part of our inspection and suggested they made a formal complaint to the registered manager who would carry out a full investigation.

The registered manager kept a log of compliments, concerns and complaints they had received. The registered manager and the provider had responded to all complaints in accordance with the provider's complaints policy and procedure. For example, one person raised a formal complaint in September 2016. The registered manager provided a detailed response to the complainant regarding their concerns. The person was happy with their response and the rationale provided by the registered manager.

Requires Improvement

Our findings

The registered manager carried out a number of audits designed to assess, monitor and improve the quality of service which people received. For example, there was an annual programme of audits which focused on areas such as management of medicines, people's care and treatment records and infection control. These audits identified shortfalls in the quality of the service, for example nursing staff had not always signed or recorded that they had administered people's prescribed medicines and not everyone had a recorded 'as required' medicine protocol for medicines which could be given when needed and sometimes at variable dosages. Whilst these concerns had been identified, there was no clear plan of action documented for how these concerns would be addressed. For example, actions around 'as required' protocols stated nurses would ensure this action was completed; however there was no clear guidance for who was responsible for the action or when the action needed to be completed. Additionally, where concerns had been identified regarding the recording of people's care and treatment records, action had not always been taken to address these concerns. There was no clear plan on how the service would use these concerns to improve the service being delivered.

The service sought the support of a pharmacist from another of the provider's services. The pharmacist provided support, analysis and guidance around medicine administration to the nurses. Whilst the pharmacist identified issues regarding missed administration records and missed medicine doses, there were no clear actions from this guidance for the service to improve. For example audits showed the amount of gaps in medicine administration records had increased from September to November 2016. This meant while concerns were being identified, action was not always being taken to address these concerns.

The registered manager and provider sought people and their relative's views regarding the quality of the service they provided, however they did not always take action regarding any concerns raised in the survey. There were no documented actions on how people and their relative's views were used to improve the quality of the service or respond to negative feedback. Audits were not always tailored to the service provided at The Dean Neurological Centre. For example, one audit in relation to infection control identified some concerns which were not always relevant for the service. We discussed this concern with the registered manager, who informed us they were reviewing their audits to identify how they can be tailored to the service to enable them to more effectively identify concerns and drive improvement.

Accidents and incidents that occurred in the service were being recorded and monitored. However actions taken were not always being recorded robustly by staff. For example, one incident reported in November 2016 raised concerns about the moving and handling skills of an agency member of staff. Whilst these

concerns had been reported, there was no documented record of the actions taken to ensure people and other staff were protected from the risk of harm. We discussed this with the registered manager who informed us they would investigate immediately. Additionally, incident reporting forms often contained a list of actions, however there was not always a clear record of which actions had been completed and how this informed people's care and treatment.

Systems to monitor the training needs of staff had generated reports which were inaccurate. The training coordinator was in the process of transferring the staff training data on to a new system but was experiencing 'teething problems' with the new system. We were informed that the provider had been made aware of the problems of the system and was working with the training coordinator to ensure a reliable system was in place which would monitor staff training and highlight any training needs. Another system to monitor the training needs of qualified nursing staff had not been kept up to date. This meant that the registered manager did not have a clear and reliable system to monitor the skills and knowledge of the work force in the centre.

Audits and governance tools were not always effective in driving improvements. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these concerns with the registered manager. They informed us that a recent provider's visit in December 2016 had identified the concerns we had found at this inspection. They informed us that as a result of the visit, they were looking to recruit a quality lead, to ensure that audits and systems were effective in driving improvements. The registered manager believed this was due to a high level of staff turnover at the service in the summer, which had unfortunately had an impact on the governance of the service. We were sent a copy of the provider's visit report after the inspection which highlighted some of our concerns as well the provider's own findings. The provider's action plan was not shared with us or the actions which had already been taken as a result of their visit, however we were assured that once completed a full actin plan would be sent to us.

The registered manager carried out monthly reports regarding the management of the service. These reports were sent to the provider and provided an overview of changes in the service and a summary of incidents, admissions and discharges. It was also used to relay concerns and some of the actions being taken to address these concerns. For example, concerns raised regarding the service in November were reported and the actions being taken were documented. However, not all actions were addressed; for example there were no recorded actions in relation to the requirement for additional staff training such as ventilator, tracheostomy and percutaneous endoscopic gastrostomy training.

The registered manager carried out quarterly meetings with people and their relatives. They used these meetings to discuss changes to the service and discuss people and their relative's views. At a recent meeting in November, the registered manager confirmed there was a reduction in agency staff being used. They also discussed recent concerns and discussed the complaints policy of the service and the ability for people and their relatives to raise safeguarding concerns to the registered manager. They stated they had an open door policy and were open to concerns being reported, as this helped the service to improve.

People were involved in making decisions at The Dean Neurological Centre. For example, one person had developed a 'Residents House Rules' which was discussed at a recent meeting with people and their relatives. These 'rules' were developed as a code of conduct for all people to follow such as respecting each other's privacy and considering each other's feelings. People agreed on these 'rules' at the meeting, and there was a plan to display these rules around the centre for people to read.

The registered manager was an experienced qualified nurse and had been in post for several years. We spoke with the registered manager about their achievement and challenges since our last inspection. They shared with us stories of people's progression while staying at the centre and their successful discharges as well as an increased number of people staying at the centre. They explained recruiting good staff had been a significant challenge. The registered manager was in daily contact with the general manager and frequently met with representatives of the provider and the managers of the other neurological centres owned by the provider.

Staff we spoke with were complimentary about the management of the centre and told us the registered manager was approachable. One staff member said, "This is one of the best places I have worked!" Regular staff meetings were carried out to ensure all staff had information they needed on the day to day running of the Dean Neurological Centre. Meeting minutes discussed actions to be completed following concerns and also addressed staff responsibilities and staffing levels on the centre. Meeting minutes provided clear guidance for staff to follow.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans, risk assessments, monitoring records and people's consent to their care and treatment were not effectively and consistently recorded. Audits and governance tools were not always effective in driving improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Some staff had not received regular training and support to carry out their roles. Staff skills and competencies were not consistently monitored and recorded.