Priory Rehabilitation Services Limited

Heathfield Neuro Rehabilitation Service

Inspection report

Tottingworth Park
Broad Oak
Heathfield
East Sussex
TN21 8UN

Tel: 01435864545
Website: www.priorygroup.com

Date of inspection visit:
04 August 2016
08 August 2016

Date of publication:
30 September 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4 and 8 August 2016 and was unannounced.

Heathfield Neuro Rehabilitation Service provides accommodation with personal and nursing care for up to 24 adults with an acquired brain injury. The service is divided into two units. Boyce unit provides long term nursing care and support for people who live with conditions such as Huntington's Chorea. Holman unit is a new unit for people with an acquired brain injury for long and short term specific rehabilitation. People were living with a range of care and nursing needs, many people needed support with all of their personal care, and some with eating, drinking and mobility. Some people on Holman unit were more independent and needed less support from staff.

People's accommodation and communal areas were provided on the ground floor. This included a gym and an adapted daily living skills kitchen (a kitchen which was height adjustable). Outside there was an enclosed garden and grounds which people could access easily with walking aides and wheel chairs. There was also a hot tub which was used for therapeutic and relaxation techniques.

Heathfield Neuro Rehabilitation Service is owned by Priory Rehabilitation Services Limited. We have received whistle blowing concerns in regard to inadequate staffing levels and lack of support and training. Due to the nature of concerns we brought the scheduled inspection forward.

There was no registered manager in post but a manager had been recruited and we were told they would be starting employment 15 August 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The clinical lead had taken on the role of acting manager and had been in this current post for three weeks. They were present on the days of the inspection.

People told us that they felt safe, but we found people's safety was being compromised in a number of areas. There were not enough suitably qualified or experienced staff at all times to meet people's needs. Not all staff had received the necessary training to meet people's specific needs and some training was out of date. Staff told us they had received supervision but it had not been regular. There were no systems in place to support staff to develop skills, identify their development needs or to check they had learnt from the training. Staff did not always treat people with dignity or respect due to the lack of training.

People were not always consulted about their care and treatment and were not involved in developing their care plans. Care plans were not always accurately maintained and updated to reflect changes to people's health. People could not rely on care being delivered in a consistent and appropriate way. Where assessments of people's needs were required they had not always been undertaken. The provision of meaningful activities was poor and some people had very little engagement and were at risk of social

isolation. Medicines were stored safely, however they were not always administered safely. There were no protocols in place for as required medicines (PRN). The provider had a policy in place but staff had not consistently adhered to this.

Staff were concerned about the quality of the service being delivered. Staff told us they did not feel supported or valued by the management and were not clear about what was expected of them or of their role. Job descriptions for new roles within the service were not in place and had not been discussed with staff.

There was no clear auditing system in place to monitor the quality of the service being delivered. Records were not in good order or always kept up to date. Records were not always stored securely to protect people's confidentiality.

However there were some areas of appropriate support for people. The provider had a policy in place which gave guidance on how to handle complaints and complaints were handled appropriately.

The provider was meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were completed in line with legal requirements. Deprivation of Liberty Safeguards had been requested for those that required them.

People spoke highly of the food. One person told us, "The food is very good; I've got no complaints whatever." Any dietary requirements were catered for and people were given regular choice on what they wished to eat and drink. Risk of malnourishment was assessed and where people had lost weight or were at risk of losing weight, guidance was in place for staff to follow.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Heathfield Neuro Rehabilitation Service and agency nurses all had registration with the nursing midwifery council (NMC), which were up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action 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?

Inadequate

Heathfield Neuro Rehabilitation Service was not safe. Risk assessments to ensure safe delivery of care were not in place for everyone and others were not up to date.

People were placed at risk from equipment which was not suitable for their needs and essential medical equipment was not checked as required and ready for use.

There was not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing deployment.

The management and administration of medicines was not always safe.

Staff had received training in how to safeguard people from abuse but were not confident about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Requires Improvement

Heathfield Neuro Rehabilitation Service was not consistently effective. There were no systems in place to check the competency of the staff following the training. Not all staff received ongoing professional development through regular supervisions, and essential training that was specific to the needs of people. Lack of end of life, and acquired brain injury care guidance and training was a particular concern.

Staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were provided with a range of nutritious foods and drinks.

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

Heathfield Neuro Rehabilitation Service was not consistently caring. Care delivery at this time was mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity.

People who remained in their bedroom received very little attention and at times people in the communal areas were left unsupervised.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks with no verbal interaction with the person involved.

However we also saw that some staff were kind and thoughtful and when possible gave reassurance to the people they supported.

Is the service responsive?

Requires Improvement

Heathfield Neuro Rehabilitation Service was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The delivery of care was not person focused or responsive to peoples individual needs,

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people who lived at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Is the service well-led?

Inadequate

Heathfield Neuro Rehabilitation Service was not well led. There was no registered manager in post. There was a lack of leadership in the management of the service which had an impact on people, staff and the service provided. Staff told us that the service was not well led.

People were put at risk because systems for monitoring quality were not effective.

Management hand not ensured that the delivery of care was

person focused or ensured that people not were left for long periods of time, with no interaction or mental stimulation.

The home had a vision and values statement, however staff were not clear on the home's direction.

Heathfield Neuro Rehabilitation Service

Detailed findings

Background to this inspection

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

The inspection took place on the 4 and 08 August 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Three inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and visited people throughout the premises, including the garden, the gym and in their bedrooms. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, five staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation. We looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Heathfield Neuro Rehabilitation Service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning of

the 4 August 2016 and the afternoon of the 8 August 2016. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people living at the service, three relatives, ten care staff,(which included agency staff) two chefs, a housekeeper, two registered nurses, the acting manager, and members of the administration and management team.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Heathfield Neuro Rehabilitation Service. Comments from people included, "I do feel safe here and I can ask for help when I need it," and "I think we are safe, no worries." A member of staff commented, "There is not enough staff to meet people's needs safely," and "It's been really hard we have no staff and can't give people the care because we haven't had the right training." We found there were shortfalls which compromised people's safety and placed people at risk from unsafe care

Peoples' risk assessments lacked sufficient information and guidance to keep people safe. The organisation used a range of risk assessments specific to health needs such as mobility, continence care, risk of falls, nutrition, pressure damage and risk of choking. The risk assessment tools looked at the identified risk and led staff to a plan of action to promote safe care. However not everyone's health, safety and wellbeing had been assessed and protected. For example, one person had been admitted to the acquired brain injury unit on the 01 August 2016 and no risk assessments had been undertaken to ensure safe care delivery. The person was unable to move independently and had come to the service for rehabilitation. The admission notes stated this person was at high risk from pressure ulcers, had specific continence needs and required a specialist mattress. Staff had not undertaken an assessment of how to move them safely, of how staff were to maintain skin integrity and prevent pressure damage, or manage their specific continence needs. Therefore there was no guidance for staff to follow to ensure the persons safety and well-being. Staff had not followed the organisational policy/protocol for risk assessments that stated the risk assessments should be completed on the first day their arrival and updated regularly throughout the rehabilitation process. The nurse told us that they "Were not sure who was responsible for undertaking the risk assessments as this was not their unit." This person was therefore at risk from inappropriate care and treatment. We asked that this persons care plan and risk assessments were put in place immediately to prevent inappropriate treatment and care being delivered.

Risk associated with the use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. The pressure relieving mattresses used by the service should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrectly could cause pressure damage. One mattress was set on 0 (this meant it was set on comfort only) and the person's weight had not been recorded. We mentioned this to staff who then approximated the person's weight as to being between 57 and 75 kgs. They told us that they would set it to between 2-3 on the gauge. This was not in line with the organisational policy which stated that each person should be weighed and a risk assessment tool completed. We also found the risks associated with the use of bed rails with pressure relieving mattresses had not been assessed and recorded to ensure that they complied with safety guidelines. For example the space between the mattress and the top of the bed rails for one person was less than that recommended by The Health and Safety Executive. People were therefore potentially at risk from falling from bed. These were discussed with the management team who told us they would check them immediately.

Good skin care involves good management of incontinence and regular change of position. There was guidance for people to receive four hourly/two hourly position changes and the use of a pressure mattress.

During the inspection, we observed people remaining in the same position for long periods of time, both in communal areas and in their bedrooms. During this time continence pads had not been checked or changed. We asked a care staff member and they confirmed that they had not been able to attend to people and manage their continence needs pro-actively. We identified that throughout the inspection, five people had not been assisted to access the toilet or offered a change position in over 5 hours. This increased the risk of skin breakdown through prolonged sitting/lying in one position and not receiving regular continence care. We looked at these five people's care plans for continence management which stated that regular checking of continence aids should be undertaken and barrier creams applied. It was acknowledged by staff that this had not happened. One staff member said, "Yes it should but the staffing problem, has prevented us doing the turns and checks, we are two staff short today." These people were therefore at risk from pressure damage.

People who lived at the service had been identified as being at risk of dehydration as they were not able to drink independently. This meant they relied on staff to assist them and ensure they received sufficient fluids to maintain their health. Risk assessments stated, 'daily fluid intake is recorded and monitored'. Records we reviewed did not reflect this and were not always completed in full, or always completed accurately. For example, on some days one person 300 mls was recorded on three days on other days some people had no fluid intake recorded. There was no target intake for staff to follow to ensure that they knew people were receiving sufficient fluids. This meant that fluid charts did not always provide meaningful information or inform staff to promote fluids to prevent dehydration.

Whilst the provider had arrangements in place for the management of medicines, we found the administration and recording of medicines were potentially unsafe. This placed people at risk of not receiving their prescribed medicines. Identification photographs of people were missing from the medicine administration charts (MAR), as were details of allergies and of individual swallow problems. This meant that agency and new staff would not be assured that they were administering medicines safely to the correct person if in communal areas. We found a large number of staff signature omissions (identified as gaps) in medication administration records (MAR). For example over a six day period there were 16 signature gaps. These gaps had not been identified by the nurse administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. There was no explanation recorded on the MAR as to why the medicines had not been administered. Some of the signature gaps were for anti-seizure medication, which if not administered as prescribed could trigger a seizure. There was also confusing directives and recording of a person's insulin and the use of an as required insulin sliding scale (which is used to regulate the blood sugar if required). The gaps in blood sugar recording and gaps for administration of insulin meant it was difficult to assess whether the treatment delivered was safe.

We observed the midday medicine being given to people by an agency nurse. Best practice guidance from National Institute for Health and Care Excellence (NICE) and organisational protocols were not being followed. We observed medicines being dispensed in the clinical room placed on a tray in unlabelled pots making identification of pills/liquids dropped or refused difficult to know. We also saw that the nurse had not taken the MAR charts with them to sign once the person had taken the medicines. The agency nurse said they knew people well enough not to need the MAR. Staff told us that they followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol and diazepam. However records had not always been completed with details of why they had been given and if it was effective in relieving the pain or the seizures. We also noted that there was a lack of directives as to when PRN medicines should be administered. For example pain charts, bowel movement charts and involuntary muscle movements. We saw that these were being produced on the second day of the inspection.

Topical creams were not consistently signed as being administered as prescribed. On discussion with the

deputy manager we were told that the care staff member who delivers personal care should sign that the cream had been applied.

The emergency equipment for use in a medical emergency such as suction machines (used to assist in removing excess saliva and mucus to aide breathing and swallowing) and oxygen cylinders were not checked regularly as stated in the organisational policy. The last checks documented were in June 2016. The equipment was not ready and fit for use, therefore placing people at risk. There were people who experienced excess saliva and mucus which was identified as a risk from choking and aspiration and therefore the suction equipment was an important piece of emergency equipment for people who lived at Heathfield Neuro Rehabilitation Service.

All of the above issues demonstrate that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe and were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to keep people safe. A formal needs assessment with relation to staffing had not been completed for each individual. There were 13 people who lived on Boyce Unit with one registered nurse (RN) and five staff members on duty to support them. All the people required two staff for support, for example, for personal care and getting dressed. It was not clear how they would meet everyone's needs with this number of staff. For example, if more than two people needed to go to the toilet at any one time. Two people also needed one to one support outside when they wanted a cigarette. There were also people who required one to one attention when they became distressed. People who live with Huntington's Chorea experience changes to their behaviours which can change quickly between apathy and aggression and excitement and depression. When we walked around Boyce Unit we saw people who were on their own in their rooms, either on bed rest or confined to a chair. We saw they were isolated and received little company or interaction apart from when they received care and support. A RN commented that the issues with staffing on Boyce Unit was that there was limited 'outings' because at least eight people needed assistance with eating so there were no staff available to take people out of the service. Another staff member told us, "There aren't enough staff to give safe good care."

On Holman Unit, there were three people and three staff, and it was difficult to locate staff. One person alone in a lounge said, "I feel I have just been left here until staff come back for me." One staff member said staffing levels "Were not great" and that both units needed more staff as most people required two staff, Another staff member told us "We haven't had the right training to look after people properly, we are expected to deliver safe care to people who have an acquired brain injury (ABI) without any training" Staff said they hadn't been provided with the training and support to look after people and that "It wasn't safe." Another staff member said, "It's really not good at the moment, no training to support us." We were also told, "Agency staff are really nice but they haven't the knowledge to really help us out, our patients are really complex."

Staff were busy throughout the day and care was not delivered in a timely manner. Personal care to assist people up for the day was still being undertaken at midday on Boyce Unit and this was not always people's individual preference. One person said, "I have been waiting all morning for a cigarette." People were not receiving timely continence care due to time constraints which impacted on people's skin integrity and their dignity. One staff member said, "It's difficult I feel totally out of my depth, it's difficult to do our job properly." An agency staff member said, "I have worked here before so I do know residents a bit but it doesn't always run smooth because of lack of consistent leadership by nurses."

Personal emergency evacuation plans (PEEP's) were in place but lack of appropriate induction for agency staff placed people at risk from failed emergency evacuations. The agency nurses and an agency health care assistant confirmed that they had not received an induction and fire procedures had not been explained to them before starting work. Therefore the provider had not ensured that there were sufficient, experienced and qualified staff to meet peoples' needs and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were in place and were up to date and appropriate. However when we asked if the concerns staff shared with us in respect of staffing issues, not being able to deliver safe and appropriate had been referred to safeguarding, they told us they hadn't because it wasn't physical abuse. So whilst staff had received training in safeguarding adults at risk, further embedding of the learning from the training is needed.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider and agency nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." However, we found staff and management at Heathfield Neuro Rehabilitation Service did not consistently provide care that was effective.

People did not always receive effective support to meet their needs because staff were not trained or supported to have the skills, knowledge and qualifications necessary to give people the right support. Staff said that they did not always feel 'confident' or 'competent' and some said they had asked for further with training but this had not happened yet. The provider had an oversight of what training had been completed across the service and of when training was due to be completed or renewed because there was an online training schedule to monitor this. The acting manager provided us with the overview of on-line training which confirmed that there were staff training needs outstanding. For example, only 57% of staff had completed fire safety, 55% of staff had completed infection control training, 73% of staff had completed safeguarding vulnerable training and 61% of staff had completed managing challenging behaviour training. We also noted 67% of staff had completed moving and handling theory but there was no record available of practical training to ensure staff were confident and competent to support people to move safely. It was not clear what competency checks were in place to embed the learning from the on-line training. Staff told us that practical sessions were needed to ensure that they were doing things in the right way because "on-line training doesn't let you ask questions when you are unsure." We discussed this with the acting manager who told us that they had identified this and would be addressing this through practical led supervisions in the future.

Service specific training, such as end of life care, ABI, Percutaneous endoscopic gastrostomy (PEG) care (a means of giving nutrition when oral intake is not adequate or safe), catheterisation and catheter care and nutrition had not been undertaken or updated to ensure best practice was followed by all staff. Comments from staff included, "I haven't had the right training and I don't feel confident, and "I need more training as I feel that I am out of my depth, I was promised training before moving to this new unit."

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said, "Supervision is a bit hit and miss but I'm told it has been organised." Staff records of supervision confirmed that staff supervision had fallen behind. Staff told us they were 'frustrated' with the lack of support, "We have one to one's but not regularly though, I don't feel they are helpful so I hold back in them" and "I haven't had supervision for over a year. It is hard work here and you get no praise." Staff told us they had felt unsupported due to staff changes, service changes and lack of leadership. This was reflected in the unsafe practices we observed. We were told that new and re-assigned staff received an induction programme and they received on-going training support. Re-assigned staff were staff who had previously being working on Boyce Unit with people with long term care needs and were now working on Holman Unit for ABI and rehabilitation. We were also told that re-assigned staff shadowed other experienced members of staff until they and the management team felt they were competent in their role. However this had not happened as we met re-assigned staff who were working independently without supervision and support. Staff said they had not had an annual appraisal to discuss

their performance and talk about their training and development needs for the past12 months. The acting manager told us, "We are setting structures for appraisals, training and supervisions".

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People commented they felt able to make their own decisions and those decisions were respected by staff. The staff we spoke with understood the principles of the Mental Capacity Act (MCA) and gave us examples of how they would follow appropriate procedures in practice. The consultant psychiatrist employed by the service undertook a mental capacity assessment on people within the service and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. The consultant psychiatrist was very well informed and provided training for staff in respect of the MCA. The documentation to support decisions made on behalf of people was clear and stated the steps taken to reach a decision about a person's capacity. Staff told us of how people's capacity could change on a daily basis and were how they changed care delivery to support those changes. One staff member said, "It is their right to be able to change their mind, we have to manage that. " During the inspection we heard staff ask people for their consent and agreement to care. For example we heard the nurse say, "Would you like to have your tablets now and, have you any discomfort?" Care staff were heard asking, "Where do you want to go, shall I help you?" and "Would you like me to help with your food?"

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). During the inspection, we saw that the acting manager had sought appropriate advice in respect of these changes in legislation and how they may affect the service. The management team knew how to make an application for consideration to deprive a person of their liberty and had submitted applications where they were deemed necessary. CQC records showed six DoLS were in place.

People told us the food was good and we saw that the menu offered choices of well-balanced nutritional food at mealtimes. Discussion with the chef told us that the kitchen team were highly motivated and proud of the service they delivered. They had undertaken research in to foods that were allergy free and had designed a new menu with photographs. The two chefs were both knowledgeable of the people they prepared food for. They assisted in delivering the meals to each unit to ensure that there was enough food and that everyone had a meal.

People had an initial nutritional assessment completed on admission. Their dietary needs and preferences were recorded. People told us that their favourite foods were always available, "They know what I like and don't like, meals are good." The chef told us, "People have a nutritional assessment when they arrive. We can cater for diabetic, vegan, soft or pureed and any other special diets. We don't have any gluten free or cultural preferences at the moment though we would be able to meet any dietetic requirement."

People's weight was regularly monitored and documented in their care plan. As stated previously some care plans had not been updated and the records for weights reflected this. An overview of weights were kept separately and monitored by the consultant psychiatrist during the monthly clinical review. We noted that for some people it stated scales not working in July 2016 but staff were currently checking people's weights and ensuring all were up to date. The acting manager said, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT) our consultants and the GP." The staff we spoke with understood people's dietary requirements and how to support people to stay healthy.

We observed the mid-day meal service. People either ate in their room or in various dining areas. The dining areas were attractive with good light. People told us they could choose where they ate, "The staff always ask me where I would like to take my meals, in my room or in the dining area." The food was well presented by the chefs and looked attractive. Staff recorded amounts eaten and ensured people ate a healthy diet. Fresh fruit was offered at meal and drink times. We were also told that snacks were available during the evening and night if someone felt hungry. One staff member said, "The kitchen is always open we can access bread, cheese and soups."
The service provided care and support to people with swallowing difficulties, for example following a stroke and for those who lived with Huntington's Chorea. The soft diet was prepared and served in divided plates so as to maximise the appearance and segregate the tastes. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking. Input from dieticians and speech and language therapists were also sourced. The service had recently recruited a SaLT who will join the team in September 2016. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. One person's care plan had a report which identified they required a 'soft, moist diet'. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this. The chef told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, we make milk shakes as well."

People's health and well-being was monitored on a day to day basis. Staff understood the importance of monitoring people for any signs of deterioration or if they required medical attention. One care staff told us, "Some people may be unable to tell us if they feel unwell, however, signs such as not eating, facial expressions or not being themselves may indicate to us something isn't right." People had regular access to healthcare professionals and GP's visited the home when required. A GP we spoke with felt staff were good at escalating any concerns and following their advice.

Each person had a multi-disciplinary care record which included information when dieticians, SALT and other healthcare professionals provided guidance and support. The provider had an occupational therapist working full time, part time psychiatrist and part time physiotherapist. This enabled a multi professional approach to providing the care delivery people needed. Input was also sourced from the falls prevention team and tissue viability nurse. People felt confident their healthcare needs were effectively managed and monitored. One person told us, "If I'm ever unwell, they always get the nurse for me."

Requires Improvement

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, and therefore there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact who were given very little time and attention throughout the day. People spoke positively of some care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived Heathfield Neuro Rehabilitation Service. Comments included, "I visit every day and sometimes it is difficult to find staff, I know they are very busy." We were also told "Very nice staff, they are kind, and "The therapy staff are really good."

Staff were task focused due to staffing shortages and therefore did not always treat everyone with respect, kindness and compassion or maintain people's dignity. Our observations identified that verbal interaction was minimal and staff lacked empathy with the people they supported. We saw examples where people were isolated and the only time people saw staff was when a 'task' was undertaken. Staff said, "We don't have time, it's just too busy, other people need us." There was a lack of engagement between staff and people and the environment and atmosphere was unstimulating. One person was seen in a recliner chair in a 45% position in the lounge and dining room for the whole day. There was no background music on and nothing provided by staff to stimulate or engage with the person. We were told "They sleep a lot of the day." The only time staff interacted with the person was at lunch when they assisted the person with their food. The care plan written by the occupational therapist stated that social interaction and stimulation was important and gave a list of things to try such as their favourite music and films.

Staff talked over people and referred to them in the third person. One member of staff said, "I will go and feed X" in the middle of the lounge and another member of staff replied, "X still needs feeding as well." This was said in a communal area in front of people and visitors. This was not respectful or dignified. There was very little meaningful interaction seen. One agency care staff member was asked to remain in the lounge area to 'keep an eye on people'. The staff member stood watching people with arms folded and did not attempt to engage with anyone.

Staff told us that they involved people in their care plan so they could be actively involved in making decisions. However this was not evident from reading care plans. For example, one person who had recently moved in had not been involved in any aspect of their care decisions. This person wanted to do house work so when they got home it would be a positive thing for their family and was very important to them. A staff member was sitting in the office writing the persons care plan whilst the person was on their own in the lounge. The staff member had not spoken with them or asked them their preferences for personal care, social input or indeed their personal goals for the rehabilitation. During a conversation the staff member said "I must admit, I could speak to them a bit more." The staff member also said they were writing the care plan "from knowing about what people who can't do much for themselves." This was a generic approach and did not promote peoples involvement in their care or treat them with dignity and respect.

The kitchen team provided pureed and soft food in a divided dish to enhance its appearance and allow the

person to taste food individually. We observed that staff immediately tipped it all together and mixed it up before assisting people to eat. When we asked staff why they mixed it together, they said it was to ensure it was of the correct consistency for the person. However this was contradictory to what the chef said. The chef said it was a 'bad habit and for staff ease and preference.' This did not promote peoples dignity.

Staff told us they respected people's privacy. Staff however did not always knock on bedroom doors and wait for a response before they entered. We saw one staff member enter a person's room pull up a cover and leave the room. No verbal exchange or permission was sought for that action with the person in that room. We also saw people in bed were left uncovered due to their involuntary muscle contractions. One person was seen uncovered for up to an hour as staff were busy elsewhere.
People's care folders and other care documentation were kept in staff offices. However on Holman Unit on many occasions we found the door open with care folders left on the desk. This meant that staff had not ensured that people's confidential information was protected.

People's independence was not always promoted. For example we observed on Holman Unit that people spent time in the communal area without staff being present. These people had no access to a call bell to summon assistance. We asked one person how they called for staff, they said, "I wait till I see someone." We also found that one person had been asked to remain in bed because staff were not sure that the purpose built wheelchair was safe. This person told us, "I don't want to be in bed all day, I need to get going." This had impacted on the person's independence and on their involvement in care decisions.

People's preferences for personal care were recorded for each person but not always followed due to lack of appropriate equipment, for example, a shower chair and staff being rushed. Staff told us one person, "always used to have a shower daily and it was important to them, but it was taken away and used on the new unit, they have not had a shower for months." Documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in up to two weeks. The acting manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes and personal care check list we looked at were not consistently completed and it was difficult to be certain of the frequency of baths and showers. Visitors shared concerns that baths and showers were not being offered regularly. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. Due to these factors, we could not be assured that people's personal hygiene needs were being met.

People were not consistently treated with dignity and respect and they were not encouraged to be involved in their care decisions or to live a life of their choice. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see staff interacting with people in a kind and compassionate way. They talked about commitment to their job, integrity and wanting to make a difference. We found that the staff shortages, low morale of staff, service changes and staff leaving had impacted negatively on how the staff were currently delivering care.

We observed staff displaying patience and empathy with people that had behaviours that challenged themselves and other people. Staff approached people in a calm and professional approach, managing to de-escalate situations with humour and compassion.

People could have visitors when they wanted. People were supported to have as much contact with family and friends as they wanted to. Where possible, people were supported to go and visit their families, relatives

and friends. During the inspection, one person told us about visits to their family and a holiday that was being planned. Visitors told us that staff were committed, kind and patient." They also said staff worked hard and that it was a shame that staff had left.

Requires Improvement

Is the service responsive?

Our findings

Whilst some people and their visitors told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to peoples' individual needs.

Communication and social well-being was an area which we identified as a concern. This was because a large amount of people were isolated in their bedrooms, and in the lounge areas, with little interaction from staff. During our inspection we noted at times there were no staff in communal areas and people were left isolated. There was no rationale given by staff or any evidence this was people's choice. One person on Holman Unit said, "I'm bored, and "Does anything happen here? I don't think so." There were also people on Boyce Unit whose only opportunity of respite from lying in their bed was meal times when they were sat up and were assisted with their meal. Staff performed tasks but they did not use this one to one time to chat or offer reassurance.

Care plans reflected some people's specific need for social interaction for example, 'likes company' and 'enjoys music' but these were not being met consistently. We were told by staff "Well they used to but their health has changed and they don't respond as much now." The care plans however did not reflect the changes or explore other ways to interact and provide something for the person to enjoy. We visited five people on Boyce Unit regularly throughout our inspection and saw they received little social interaction from staff, apart from being given drinks and their meals. We observed staff waking one person for their lunch meal and they dozed off again once they had eaten. We looked at the person's care plan. It did not contain any information or guidance of how staff could engage with the person. We spoke to the agency staff member who was assisting them and they said they didn't know the person and didn't know what to say.

Activities promoted were not fully reflective of people's individual interests and hobbies. Across the whole service people were not supported and encouraged to keep occupied. There was not a range of meaningful activities available, on a one to one or a group basis, to reduce the risk of social isolation. One person commented, "It's alright here, I spend most of my time in the gym but it is boring and the evenings drag," and another person said "I can't remember going out. Sometimes I go out in the garden but I can't remember when". One person told us that trips out would be good but it was not clear from talking to staff if outings were offered or planned. A staff member said "They went on a boat trip recently but only a few can go because of the extra staff needed." During our inspection we only saw one staff led activity for three people on Boyce Unit. This was held outside with only one person participating in the ball game. Staff said "We try to encourage people to join in games but to be honest not many want to."

We visited people in their bedrooms throughout the home and observed some people lying in bed with nothing to visually engage with or listen to. They spent most of the time asleep and were disengaged.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. We found that five of the six care plans viewed had not been updated to reflect

peoples changing needs. One persons' care plan stated 'communication cards kept on back of wheelchair' but the person was now supported in bed and there were no communication cards available. The care plans for care delivery had not been changed to reflect the increased involuntary movements and the treatment changes, such as being safer in bed with buffers for protection. These were reflected in the case review notes but not in the main care plan. Another person's nutritional plan was incorrect and had not been updated to reflect their changed nutritional needs. Care plans therefore were out of date and would be confusing to agency and new staff. The lack of accurate information meant staff would not be able to respond to people's individual needs, and placed them at risk from inappropriate care and treatment.

The evidence above demonstrates that delivery of care in Heathfield Neuro Rehabilitation Service at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Holman Unit was a specialised rehabilitation unit for ABI and the accommodation had been extensively refurbished to accommodate this specialism and meet individual specific needs. The occupational therapist worked alongside a part time physiotherapist to devise specific individualised care plans with achievable goals. These goals were set with each person and monitored to ensure they were achievable. There were comfortable communal lounges which were spacious enough for people to self-propel themselves in wheelchairs. En suite bathrooms were spacious and equipped with specialised equipment to promote and encourage independence with support from the occupational therapist and the therapy co-ordinators. An adapted daily living skills kitchen was also available and people were actively encouraged with support to make tea and coffee. We were told "As we progress with people, I hope we can get people cooking and baking, hasn't happened yet but it will." There was also a gym which had various exercise equipment to strengthen muscles and improve balance and dexterity. One person said, "it's hard work and I push myself to the maximum because I want to go home and live a normal life." This person also had praise for the support they received from staff.

A complaints procedure was in place and displayed in the reception area and communal areas of the home. These were also provided to people in an accessible format such as large print and pictorial. A visitor said, "I am confident that I can raise any concerns or grumble and the team ensure it's dealt with." Complaints received were logged and documentation confirmed complaints were investigated and feedback was given to the complainant.

We were told that satisfaction surveys had been sent out in the early part of 2015, but not since the service had changed. There had been a large amount of changes to the service in the past year, including management and staff changes. We were told further surveys would be sent out in the near future now that the service was more settled and Holman unit opened.

Inadequate

Is the service well-led?

Our findings

The feedback from people, staff and visitors about the leadership in the home was varied. Comments from visitors included, "I think there have been problems with staff, and I believe the manager has left," and "I feel the use of such large amounts of agency staff has really affected the atmosphere, the care and my fear is however nice they are, the staff don't always know the residents well enough." Staff said, "It's a bit of a struggle, because so many good staff have left, there always an element of panic, because of the amount of agency, but the management have said new staff are being recruited." Nurses from the agency felt unsupported when they came in, "I was just expected to get on with it, I didn't have an induction and felt a bit out of my depth."

There was no registered manager in post. There have been seven managers in two years. A manager had been recruited and was due to start work on the 15 August 2016. The deputy manager was at present in day to day charge supported by the area manager and administration team. We were told that the organisation were looking to employ clinical leads that would be working on each individual unit. The clinical leads would then report back to the management team.

The service was not well led and lacked leadership. This had a detrimental impact on the service people received. People did not always get their needs met, and people were at risk of unsafe care and treatment as staff did not have the skills to keep people safe.

There was no clear auditing system in place to monitor the quality of the service being delivered. Audits had been completed but there were no records of what action needed to be taken, by whom and when it should be completed by. We were told that these had been done by the previous acting manager but staff had not seen any action plans. Staff said they were not sure who was responsible for auditing the medicines and medical equipment. This inspection found that the audits for medicines were not robust. For example, on Boyce Unit, staff told us they checked the temperature of the clinical room and clinical fridge but records showed this was not completed consistently. The diabetic blood test machines were due for checking and calibration on a monthly basis but had not been done since May 2016 as no test kits were available. These issues had not been identified or reported by staff.

Records were not in good order or always kept up to date. We reviewed the staff rota for the week, with the acting manager. She was unable to give us a clear explanation of who was working on that day (4 August 2016) and on what unit, due to numerous errors on the rota. It was also not clear from the rota if agency staff had been successfully booked for that night. The acting manager was working excess hours herself on the floor and told us if she was unable to get agency staff for that night she would have to work the night shift after a full day at work. She informed us later an agency nurse had been allocated for that night.

When we asked for certain information it was not available. For example, the provider did not have any analysis of accidents and incidents to identify patterns and trends over the past six months.

Accurate and complete records in respect of each person's care had not been maintained. Records of the

care and support people received or offered were sometimes limited. There was minimum reflection of people's emotional and mental health status which would enable management to deploy staff effectively and safely. People were at risk because decisions about their care were made based on inaccurate or incomplete information. Due to the nature of the health conditions people lived with, many had swallowing difficulties. They had been assessed by a speech and language therapist (SaLT) and a plan to ensure peoples' safety whilst eating and drinking had been put in place. However we saw that staff were not following the instructions. For example, one person's care plan stated that the person should be sitting upright, fully awake, engaged with and never be assisted with food or drink in a reclined position. We saw this person assisted to eat in a reclined position with their eyes closed and no verbal engagement. Staff told us, "The swallow needs have changed now and it's safer to assist in a reclined position." However this was not documented, the risk assessment had not been updated, nor a re-assessment requested from the SaLT. As there were a high use of agency staff and new staff being recruited this conflicting information placed the person at risk of inappropriate care. The provider therefore did not have systems and processes in operation to maintain an accurate and complete record in respect of each person, including decisions taken in relation to their care.

The provider did not have the required oversight and scrutiny to support the service. Staff told us they were not confident that the provider knew what was happening at the service. The provider had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. For example, there were no documented observations of staff performance or competency assessments. The provider had not ensured that the care provided was safe, that staff were trained effectively or that care was person centred.

Staff were concerned about the quality of the service being delivered. Staff told us they did not feel supported or valued by the management and were not clear about what was expected of them. Staff said they did not understand their roles and responsibilities and were not clear of their individual responsibilities on each shift. Staff had not received a job description or induction in to the new role. One member of staff told us that they "Felt let down by the management through the changes." This was confirmed as an issue in the minutes of a staff meeting held on 2 August 2016.
The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and staff knew where to access the information they needed. For example Staff were aware of the whistle blowing policy and how to blow the whistle on poor practice to agencies outside the organisation. They were also aware of internal processes for raising concerns confidentially. However staff said they were not confident that the management would listen and act on what they said so had chosen to use external agencies. Staff feedback had not been sought and had not been used to support the staff team through service and management changes. Feedback on the service provided from people, visitors and health professionals had not been obtained by the provider so they could use it to continually evaluate and improve the service. The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not feel that there was an open and transparent culture. Staff said that they did not feel supported and enabled to question practice or raise issues about the quality of service delivered. Staff told us that when suggestions had been made they did not feel they had been listened to and that they were 'talking to a brick wall'. Staff told us, "Morale is quite low. The staffing levels and staff leaving have had a huge impact on staff. I think there is a lot of pressure on the acting manager," "We do have a good team here but we don't feel appreciated. I always thank staff but we don't get much [thanks] from the management," "I feel valued by our resident doctor, occupational therapist and sometimes by the acting manager, but 'upstairs' [management] doesn't listen. They could improve how they make changes, reassure us and improve the way they talk to us" and "I like it here most of the time. Some days other staff might not pull their weight. The

floor could be managed better."

The acting manager said, "Teams either come together or fall apart and I think everyone here is now pulling together. We have been making improvements in the last month." We asked staff for their views on the management and leadership of the service. Some staff said that, "We haven't been listened to or involved in the changes to our work place. We have suddenly had our job changed but no training or job description," "Management is getting better over the past two weeks," "I don't feel supported at all. Nothing changes. I don't feel valued" and "We are not in a good place, it's got to change and with a new full time manager perhaps it will."

We asked staff about the vision of the service and staff told us, "We know what the management says the vision is, but I'm not sure the vision is clear to all staff." Another staff member said, "The vision has changed, we were a hospital and now we are a care home and we are struggling to understand the new vision."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC uses this information to check that appropriate action had been taken including action to keep people safe. Notifications of incidents that affected people's health, safety and welfare had been submitted to CQC in an appropriate and timely manner in line with CQC guidelines so we were aware of the number and significance of events which had occurred at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. The provider had not ensured that service users were involved in decisions regarding their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. The provider had not ensured the supporting of the autonomy, independence and involvement in the community of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks. The provider had not ensured that the equipment used by the service provider for

providing care or treatment to a service user is safe for such use and is used in a safe way.

The provider had not ensured the proper and safe management of medicines

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 The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place and had not maintained accurate, complete and contemporaneous records in respect of each service user

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 The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision