Ramsay Health Care UK Operations Limited

The Dean Neurological Centre

Inspection report

Tewkesbury Road
Longford
Gloucester
Gloucestershire GL2 9EE
Tel: 01452 420200
Website: www.ramsayhealth.co.uk

Date of inspection visit: 6 November 2014
Date of publication: 19/12/2014

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection was unannounced. A full inspection of the service was last completed in June 2013. We found breaches of legal requirements in the following areas: respecting and involving people, consent to care and treatment and the management of medicines. A follow up inspection was completed in December 2013 and the required improvements had been achieved.

The Dean is registered to care for up to 60 people who have complex neurological or spinal related disease or injury. People may have long-term physical and/or cognitive impairment, which may not improve over time and which may also require long-term medical support. The service provides specialised 24 hour nursing care and therapy services for adults over the age of 18. There were 45 people receiving care at The Dean when we visited.

Summary of findings

There was a registered manager in post at the service. 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 of the Health and Social Care Act and associated Regulations about how the service is run.

All staff ensured that people were kept safe and safeguarded from harm. They all received safeguarding adults training and understood their role and responsibilities to protect people from harm. Appropriate actions had been taken when safeguarding concerns had been raised. Information was available for staff to say what they had to do if safeguarding concerns were raised and who they had to contact.

There were good risk assessments and management plans in place to ensure that any risks in respect of people's daily lives or their health needs were properly managed. The plans ensured that those risks were reduced or eliminated. Staffing numbers on each shift were sufficient to ensure that each person was kept safe and their care needs were met.

All staff were provided with the training they needed to do their jobs and had further training opportunities to develop their skills. Staff had the specific clinical skills they needed to meet people's individual and complex care needs. People were provided with sufficient food and drink, or dietary supplements to meet their requirements. Where people were at risk of poor nutrition or hydration, measures were in place to monitor how things were going. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

There were positive working relationships between the staff and people who lived in the home and people were well cared for. Where possible people were involved in making decisions about how they wanted to be looked after and how they spent their time. Families were involved in the decision making process where they needed and acted as an advocate on behalf of their relative. People's privacy and dignity was maintained at all times.

People were encouraged to have a say and to express their views and opinions about their care and each person was looked after in a person-centred way. They had a say about the way the home was run, meals and activities. Staff listened to what they had to say and acted upon any concerns to improve the service they provided.

The registered manager provided good leadership and had a committed staff team who provided the best possible service to each person who lived there. The quality of service provision and care was continually monitored and where shortfalls were identified actions were taken to address the issues.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from harm. Staff were aware of their responsibilities to safeguard people and had reported any concerns that were raised with the appropriate authorities. The procedures for recruiting staff were safe and ensured suitable staff were employed to work in the home.

Risks were well managed and enabled people to be as independent as possible and to be kept safe. Medicines were well managed and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff had the necessary knowledge and skills to be able to look after people's complex care needs. They were well trained and provided with good support in order to do their jobs.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. The registered manager was aware of the requirements of the DoLS. Appropriate steps had been taken to ensure the correct authorisations were in place. People's rights were properly recognised, respected and promoted.

People were supported to have enough to eat and drink and their specific dietary requirements were met. Where there was a risk of poor nutrition or dehydration measures were in place to monitor this.

People's health care needs were met and staff worked with the GPs and other healthcare professionals to ensure peoples well-being was maintained.

Is the service caring?

Good

The service was caring.

The Dean is a welcoming and friendly home and the people who lived there were positive about the way they were looked after and the staff team. The staff had good working relationships with them and provided the support people needed. People were treated with respect and dignity.

Where possible people were involved in making decisions about their care and support. They were looked after in the way they wanted and staff took account of their personal choices and preferences.

Is the service responsive?

Good

The service was responsive.

People were involved in the process of making decisions where possible and received the care and support they needed. Staff knew how each person needed to be looked after and what their preferences, likes and dislikes were.

People had opportunities to take part in some social activities however there was an acknowledgement that the activity programme needed to be expanded. People were supported with external activities where possible.

Summary of findings

Is the service well-led?

Good

The service was well-led.

The home was well run and all staff were committed to meeting each person's individual care and support needs. The registered manager had a visible presence in the home, was approachable and provided good leadership.

Robust auditing systems were in place to measure the quality of service provided to each person and to identify where improvements were needed. Any comments or complaints people had were listened to and acted upon appropriately.

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, and to provide a rating for the service under the Care Act 2014.

The last inspection of The Dean Neurological Centre was completed in June 2013. We found breaches of legal requirements in the following areas: respecting and involving people, consent to care and treatment, and the management of medicines. A follow up inspection was completed in December 2013 and the required improvements had been achieved.

The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor had a medical background and experience in this type of service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. 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, tells us about what the service does well and any improvements they planned to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We contacted 15 health or social care professionals before our inspection and asked them to share both positive and negative feedback with us. We received feedback from five of the professionals we contacted. We used this information to inform the inspection planning process.

During the inspection we spoke with 16 people who lived in The Dean and six relatives. We spoke with the registered manager and 13 members of the staff team. We also spoke with a Senior Nurse from an NHS Trust who funded five people who lived at The Dean and was exploring the possibility for further placements and one of the GPs who regularly visits the home and monitors peoples health care needs.

Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework session (SOFI) during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

We looked at six care records, three staff recruitment files and training records, staff duty rotas and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe at The Dean and were well looked after. They said "I feel safe being hoisted or when using other mobilising devices", "I use a standing aid to transfer with the help of two staff. I always feel safe as they support me well", "The carers always involve me and talk to me, rather than at me" and "They take their time and I feel safe when they have to hoist me". One relative told us "My husband never likes being hoisted, but staff have taken the time to make him feel more secure and safe".

We asked staff to tell us how they ensured that people were safeguarded from harm. Staff understood their responsibilities for safeguarding the people who lived in the home. They were able to tell us about the different types of abuse and how they would know someone without verbal communication skills may present if they were unhappy. Staff said they would report any concerns they had about people's safety to the manager or the nurse in charge. They knew they could report directly to Gloucestershire County Council, the police or the Care Quality Commission. In the PIR the registered manager stated all staff completed a safeguarding adults training programme accredited by Gloucestershire County Council. This training was refreshed on a three yearly basis.

The providers safeguarding adults at risk from abuse or neglect policy and procedure was last reviewed in July 2014 and included reporting protocols if abuse was witnessed, alleged or suspected. The provider also had a disclosure of information (whistle blower) policy. Staff knew how to access these policies and information was also displayed in the staff room.

The registered manager has demonstrated a clear understanding of safeguarding adults and had worked with other agencies and healthcare professionals in an open and transparent way when concerns were raised by the family of an individual or by the staff team.

A sample of staff personnel files were checked to ensure that recruitment procedures were safe. Appropriate checks had been completed. Written application forms, two written references and evidence of the person's identity were obtained. References were followed up to verify their authenticity and two senior members of staff did all interviews. Disclosure and Barring Service (DBS) checks were carried out for all staff. These were police checks carried out to ensure that care workers were not barred from working with vulnerable adults. These measures ensured that only suitable staff were employed.

To ensure people's safety was maintained a range of risks assessments were completed for every person. These included assessments in respect of the likelihood of developing pressure ulcers, falls, nutrition, the use of bed rails and moving and handling procedures. Where staff were required to transfer people from one place to another, a moving and handling plan of care was devised. These set out the equipment to be used and the number of staff required to complete the task safely.

People with capacity were supported to do as much as possible for themselves. Staff provided the appropriate level of support to those with mental impairment or reduced mobility as had been determined during the care planning process. Where people required constant supervision they were funded for and provided with, a member of staff to remain with them at all times. In the PIR the registered manager told us where the behaviours of one person could put others at risk, they worked with the funding authorities to ensure that appropriate interventions by the staff team were in place, or an alternative placement was found. For each person the capacity to make informed choices and the risk associated with the activity were assessed.

The Fire and Rescue Service last visited in September 2014 following an external small fire within the grounds. Recommendations made by them were in the process of being implemented. There was a fire risk assessment in place and the fire policy had last been updated in May 2014.

The provider had a business continuity plan in place. This included information about alternative accommodation and services in the event of an emergency such as severe weather conditions, staff shortages and loss of utility services. Personal emergency evacuation plans had been prepared for each person: these detailed what support the person would require in the event of needing to be evacuated from the building.

Good

Is the service safe?

Records were kept of checks of the fire alarm systems, fire fighting equipment, fire doors, hot and cold water temperature checks and the call bell system. All hoisting equipment had been serviced and contracts were set up for six monthly checks.

Staffing levels were kept under constant review by the registered manager and were adjusted based upon the needs of people who lived in The Dean and activities taking place. The home was supported by two clinical lead nurses (one for days and the other for nights) plus there was also a lead therapist. Shifts were covered with a mix of care staff (nurses and care staff), therapists and therapy aids, administrative and housekeeping staff. Two nurses were on duty on each floor on the day we inspected. Staff felt that staffing levels were appropriate and people we spoke with said there were always staff about to help them. The Dean needed to use agency staff at times because of changes in peoples individual needs and a recent increased numbers of people who lived at The Dean. Where people needed constant supervision because of their ventilator to help them breathe, in-house staff were used to provide that support and agency staff were used for general nursing and caring duties. We found that people were looked after by staff who were familiar with their needs and preferences.

People were unable to look after and administer their own medicines therefore all medicines were managed by the nursing team. Nurses re-ordered medicines on a four weekly basis and ensured that people's medicines were always available for them. The supplying pharmacy provided printed medicines administration record (MAR) charts for each person: these showed what medicines were prescribed and when they had to be administered. New supplies of medicines were checked against the MAR charts and the GP prescriptions to ensure they were correct. The nurse signed in how many medicines had been received.

On the ground floor, 15 of the bedrooms had a piped oxygen supply and suction equipment. The Dean also had a supply of oxygen in cylinders in case of any medical emergency or equipment failure and also enabled those people who needed constant oxygen therapy to move away from their room for periods of time. Further supplies of cylinders were appropriately and securely stored in a locked cage outside of the home.

We looked at a sample of MAR charts on one floor. There were no gaps and the nurse explained they checked all the MAR's at the end of their shift to ensure the charts had been completed properly. Stocks of controlled drugs (and other medicines where the stock levels were monitored) were checked each time they were administered, and records were kept of the checks and signed by two nurses.

All medicines were appropriately stored with each person having their own cabinet within the medicines trolley. Some people had an emergency stock of medicines for example antibiotics, but nurses had to contact the GP for authorisation before commencing treatment. Where people were prescribed medicines that were administered 'as and when needed', protocols were in place that set out the criteria for administering the medicine.

All medicines were kept safely in the locked clinical rooms on each floor. A medicines refrigerator was available in each clinical room and the temperature of the refrigerator was checked on a daily basis. Records we saw indicated that medicines were stored at the correct temperature. Suitable arrangements were in place for the disposal of unwanted medicines.

Because of the high number of people who required their medicines to be administered through a gastrostomy tube (a feeding tube inserted directly into the stomach), there were plans senior care staff who had completed a level three national vocational qualification would be trained up to assist with gastrostomy administration of medicines.

Good

Is the service effective?

Our findings

People told us "I get the help I need", "The staff are very confident in what they are doing and is very reassuring for me", "I am settled here now and the staff know how I like things done" and "I have made a lot of improvement since I have been here, but I am still frustrated by the slow process of getting better". One visitor told us "Things are improving for my husband. The staff team keep me informed how things are going". Another relative said "The staff do all they can".

Staff told us they had received an induction training programme when they had first started in post and this had prepared them for their role. They said the training was thorough and included mandatory training such as fire safety, moving and handling, safeguarding and infection control. New staff were allocated a mentor or "buddy" to help them settle in and worked for a number of shifts with other more experienced staff. New staff had a six month probationary period to complete and attended regular supervision meetings with senior staff. This gave new staff the opportunity to discuss the progress they were making in their new role.

Staff told us they were competent to carry out the duties expected of them. They asked if they were unsure about any procedure or aspect of care delivery. Staff told us they were supported to do their jobs and "everyone works to the benefit of people they were looking after". They received the appropriate training for their role and had meetings with their line manager to talk about their work. Several members of staff told us they wanted supervisions to take place more frequently. One member of staff said, "I don't really know how I am getting on. We always get shown if we are undertaking new procedures, but it would be nice to have a regular meeting to discuss my work".

Annual appraisals were undertaken for all staff. Supervisions were expected to be completed for staff member every six to eight weeks. We spoke with staff and viewed a sample of supervision records. The supervision meetings had not been taking place as frequently as stated but the registered manager was aware of the shortfall and had a plan in place to make improvements.

The Dean had a training plan for the year. The training lead planned and organised staff training kept an overall record to show what training each staff member had completed and when refresher training was due. Records provided details about additional training provided to support individual job roles. Examples included one nurse who had completed tissue viability training following which they provided advice and guidance to other staff and acted as the tissue viability 'Link Nurse'. Another member of staff had completed additional training to enable them to provide a training programme for staff caring for people who were supported with ventilators, tracheostomies and suction therapy. We saw the record of training programme completed and copies were kept in each member of staff's continuous professional development folder.

Nursing staff and therapists were supported to keep up to date with their professional practice. There were good communications and liaison with other health professionals, for example the Speech and Language Therapist (SALT), Huntington's Lead Nurse, Physiotherapists and Occupational Therapists.

The overall staff training record showed that 41% staff had completed their mandatory e-learning refresher training. Staff confirmed that they had already been 'chased up' to complete their e-learning programmes. One staff member told us they struggled with using the computer and would prefer teaching sessions. The training lead does give support to staff who lack computer skills, these were on a one to one basis. Training records confirmed that 98% staff had completed the practical element of moving and handling training. There was already a plan in place to improve the completion of e-learning training.

The majority of care staff were undertaking or had completed national vocational qualifications (NVQ's) ranging from levels two to five. Three staff who were in the process of completing the eight common induction standards modules will enrol for NVQ training upon completion of their induction training.

Staff told us they had received training and had an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The

Good

Is the service effective?

safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

The registered manager told us that five people had a DoLS authorisation in place; however other staff we spoke with were not aware of which individuals had a DoLS in place. The registered manager had completed MCA and DoLS training with Gloucestershire County Council and demonstrated a good understanding of issues relevant to all these areas. The registered manager understood when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Staff explained how they made sure people were involved in making decisions and choices about their care. We received the following comments from staff: “We try to involve the person to make their own decisions. We use equipment such as alphabet boards, some people communicate by blinking, and some people use computers”, “It is really good to see how some people’s capacity to be involved improves as their rehabilitation programme progresses” and “We constantly reassure people if they can’t easily communicate verbally”.

Care plans contained mental capacity assessments, details about how ‘best interest’ decisions had been made and who was involved in the process and where a power of attorney instruction was in place. We were told how one person had received support from an advocate. The registered manager arranged meetings with senior nurses, other health professionals and families and the outcomes and agreements made were documented in the person’s care plan.

Where people had a ‘Do not Resuscitate’ (DNR) record in their care notes, this was reviewed regularly and discussed with the person’s GP. We saw records that confirmed who had been involved and when reviews had taken place.

Several people were at risk of choking and we looked at the care plan for one person. The SALT team and the dietician had been involved in planning the diet for this person. Staff were not allowed to support the person with their fluids and diet unless they had completed SALT training. The care plan described the actions required in the event of the person choking.

The chef manager explained people selected their menus on a weekly basis. There were at least two choices for each meal. Cooked breakfasts were not offered unless there was an identified special dietary requirement. Breakfasts were served from 8am; lunch was the main meal of the day and was served from 12.30pm on the first floor, and from 1pm on the ground floor. The chef told us the numbers of people using the service had recently increased and they would soon require a second trolley for the main meal service to ensure people were served their meals at the correct temperature. Supper was served from 5.30pm and usually consisted of soup, sandwiches and a dessert for people on a ‘normal’ diet.

The chef manager provided meals from The Winfield Hospital (on same site). They provided 32 meals of which 11 were of a soft/pureed consistency. The chef received support and advice from the dietician when planning the menus. People’s body weight was monitored and where there was weight loss a management plan was in place. Supplements and fortified foods were provided if needed. A member of staff said, “We can also note down any concerns or queries we have in a book which the dietician reviews twice each week”.

The meal ordering system wasn't particularly liked by people, as they had to make dinner and tea time meal choices a week in advance. The overall feedback we received was people did not always feel like eating what they have chosen previously. One relative told us "She doesn't like much of the food so we bring in all the things she likes to eat".

We observed the meal service on one floor. Eleven people were supported with their lunch in the dining room and two people had chosen to eat in their bedroom. The main meal looked appetising and nutritious. Most people had chosen the roast dinner: the alternative was sausages and chips. Pureed and soft diets were well presented but staff said they were not always aware of the components of pureed meals. We found the dining room to be noisy: the television was on with the volume quite high and there did not appear to be anyone watching it. The mealtime was not organised to provide an enjoyable or sociable experience.

Good

Is the service effective?

Fluid and nutrition charts completed were for those people who were supported with enteral feeding regimes. The charts had been fully completed. The target amount of fluid the person required in a 24 hour period had been documented by the dietician.

Each person was registered with a local GP practice where there were three GPs. One of the GPs visited daily during the week and also provided on call cover 24 hours per day. The practice had been involved with The Dean since the service opened. People's notes were currently kept at the surgery however there were plans in place to set up a secure computer link so that staff had access to 'patient' data (if the person agreed). We met one of the GPs during our inspection who were very positive about The Dean and felt that the service was now "very settled and progressive".

Monthly multi-disciplinary team (MDT) meetings were held to discuss each person's health and rehabilitation status. Records confirmed who had been involved in these meetings and when reviews had taken place. MDT action sheets were completed to record clinical, nursing and therapy decisions made.

The therapy team consisted of two physiotherapists, one part time speech and language therapist, one occupational therapists, four therapy assistants and an activities coordinator. The level of therapy support each person received was determined during the assessment process and depended upon the funding arrangements in place. Weekly rehabilitation meetings commenced in September 2014 to ensure effectiveness of the rehabilitation programme and to change practice where necessary.

Arrangements were made for people to see opticians, dentists and chiropodists as and when needed. One relative told us "They have even taken him to see a dentist without me having to ask". The home worked alongside community and hospital social workers, lead nurses for complex neurological disorders and the Continuing Health Care Nurses, in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

Our overall impression when we visited was The Dean was welcoming & friendly and this was backed up by comments made by the people who lived there, their relatives and the staff team. Each person, and the relatives we spoke with were pleased with the standard of care provided. Each person was neatly dressed in clean clothing, were well groomed and there were no unpleasant odours. People were offered daily showers or bath and were treated with respect and dignity. Staff gave us examples of how they respected people's dignity: "We always ensure bedroom doors are closed when we are delivering personal care" and "I respect people and listen to what they say".

People told us "The staff all look after me very well. They talk to me about what they are doing and I never feel rushed as it takes me more time to do things since my stroke", "The staff are caring and take their time with me", "Carers are all very friendly and spend time with me when they can" and "I am happy here and staff are kind and polite to me".

Relatives we spoke with had the following comments to make: "For the first time since he went into care I have peace of mind because I know he is being well cared for" (this person had lived in other care establishments prior to The Dean), "She likes some staff better than others and she can be quite rude at times to staff she doesn't like" and "All the staff genuinely care, and welcome us as visitors when we arrive".

During our visit we observed caring and friendly relationships between care staff and the person they were looking after. We saw one member of the care team kneeling by a person's bedside and holding their hand whilst they comforted the person. We saw positive interactions with people during the mealtime where staff were supporting the person with sensitivity and compassion.

Both the therapy staff and care staff knew the people they were looking after well and we heard them addressing them in an appropriate manner. The therapists told us there was good communication with the care team so all staff could develop a good knowledge of each person and build up trusting relationships.

Staff were committed to caring for people in the best possible way and understood the role that good communication played in them establishing sound working relationships. Staff were aware of the importance of verbal and non-verbal communication and how this determined whether a person was happy with the care they were receiving. Staff gave people the opportunity to make choices about their daytime activities, where they spent their time and when they received personal care support. People were supported to express their views and to be as involved as possible in making decisions about their care and their daily lives.

Good

Is the service responsive?

Our findings

People were positive about the care and support they received. Staff told us people were supported to contribute to their care plans as much as they were able. Families were involved as appropriate and where agreement had been made for them to be involved. The multi-disciplinary team involvement to ensure that people received the exact care and support they needed was evident. One member of staff said, "We really try to find out as much as possible about each person. We have residents with very little verbal understanding so we seek input from families and other people". Another member of staff said, "For one person we consulted with their high priest to find out about their future wishes".

There was a general acknowledgement from the staff spoken with that the activity programme needed to be expanded. People said "I have an hour of physio and speech therapy a day, but other than this, I usually spend the rest of the day in my room watching TV", "My wife visits and will wheel me about outside if the weather is ok. I have never been offered an outing with the staff", " I do get bored during the day but a new bible study group has just started which I enjoy" and "I have enjoyed doing some artwork, I wish there were more opportunities to do things like this" and "I would like more things to do, the day can be long". One person told us "My brother is really good and organises outings for me to go on", and added "otherwise I would not go outside". Some people had their own transport and were able to go out with their families or on their own.

People and relatives said there was not enough to keep them occupied during the day with few opportunities to go outside or away from the home. We spent time with the activities coordinator (AO). They told us that there was a weekly plan of activities but these were generally activities with a small group of people. On the day we visited we observed a game of scrabble taking place with three people. We noted that the televisions in communal areas were on all day and there were long periods of time with people sitting in the communal areas with the television on, with no other apparent activity taking place. One healthcare professional said that when they visited, the person they were seeing was "always plonked in front of the TV".

Outings should happen on a twice monthly basis but only three people and three care staff were able to go at any one time. The AO relied upon the availability of volunteer care staff to arrange any outings. None of the people we spoke with told us they had been out on any recent outing; however we were aware that there had been outings to Slimbridge Wildlife Centre and The Willow Canal Boat. On a positive note a healthcare professional told us one person was supported to attend a sporting activities "and they would not have had this opportunity if they were living in a standard care home". External 'entertainers' were arranged and these included zumba (dance based exercise), 'fun and games', cookery and gardening. Volunteers also visited the home – 'Pat a Dog' and art groups from the local college.

Feedback we received from one healthcare professional, our own observations during the inspection and comments received from members of the staff team, were care staff who provided one to one (1:1) care for an individual could be more proactive in meeting peoples social needs. We saw 1:1 care staff sitting watching television with people, or sitting outside of the room and reading newspapers, or talking to their colleagues whilst keeping an eye on the person they were supervising.

Care records we looked at included an initial assessment of needs, completed prior to admission. These assessments were comprehensive and had been completed by the registered manager and the lead therapist. These measures ensured that The Dean and the staff would be able to meet the person's needs. Risk assessment and management plans were devised for each person and provided details about personal care needs, mobility, support needed with eating and drinking, any wound care management and their night time requirements. Care plans were well written and provided detailed information about how the planned care was to be provided. Daily records of care provided were maintained during each shift. Care plans were reviewed during multi-disciplinary team meetings to ensure they remained up to date and people received the support they needed. The care plans reflected people's care needs as they had been described to us and provided an accurate picture of the person's needs.

Each staff member coming on shift received a handover report from the outgoing day or night staff. These handover reports were recorded and listened to by those staff who were starting their shifts at different times of the day. Staff who provided 1:1 care handed over verbally to the staff

Good

Is the service responsive?

member taking over from them. These measures ensured they received detailed information to enable them to provide the care required by each person and were made aware of any changes.

There were opportunities for the people who lived in The Dean and their relatives to have a say about the service provided. A 'Resident' feedback survey had been completed in May 2014 but was only completed by 25% of the people who lived at the home at the time. People were asked to comment about the nursing/care input, the therapy staff, housekeeping and cleanliness, management and activities. 'Resident and Family Forum' meetings had been held in May and October 2014: the meeting notes stated what had been discussed but did not detail any actions taken or planned.

The Dean's complaints procedure was displayed in the main reception area. The administration assistant told us they were often the "first member of staff people speak to informally, if they had queries or concerns" and they would ensure this was passed on to the registered manager or the nurse in charge. People told us they felt able to raise any concerns they had with the staff and they were listened to and taken seriously. One person said, "I can talk to the staff about any concerns I have". Others said they had not made any formal complaints but would talk to their relatives first or approach the manager of the unit if necessary.

Good

Is the service well-led?

Our findings

People and relatives said "Everything seems very well organised", "We always find the home to be meeting the needs of our relative" and "We get to see the manager or at least the nurse in charge every time we visit".

Staff commented that the service was well-led and that they were able to see the registered manager if they had any concerns they needed to discuss. The registered manager's office is located off the main reception area, they therefore had a visible presence in the home. Staff said, "We are encouraged to have a say about people's care and we are listened to", "We are supported by the manager when things are difficult" and "There is a good staff team here but we do need more permanent staff now there are more residents". The registered manager told us there was a huge recruitment drive in place where they hoped to recruit four more nurses and two senior nurses.

In the PIR the registered manager wrote about the formal and informal processes in place to gather feedback from people, their relatives and the staff team. There was an audit programme in place to ensure the quality of service provision was maintained. The registered manager said there was an open door policy and this was confirmed during our inspection. The aims of the service was to assist people in their recovery from a life-changing event or to maximise an individual's abilities, comfort and quality of life, whilst living with their degenerative neurological condition. It was evident in all our conversations with staff, people who lived in The Dean and their visitors, that this was an aim shared by all.

The registered manager ensured there were good working relationships with the local authority, the NHS and commissioning bodies. In the PIR the registered manager spoke about working with 'other outside professionals' to improve the quality and satisfaction for respite people. They did this by sharing information about care needs and expectations.

Three monthly staff meetings enabled all staff to have a say about how things were going and suggestions about meeting people's needs in a different way where something was not working well. Staff were encouraged to "make their own agenda" and to "come up with solutions to the concerns they raised". Staff told us they were encouraged to question the managers about matters and could raise concerns if need be. Staff said there was a whistle blowing policy and there was an expectation they would report any bad practice. The lead therapist also held meetings with the therapy staff on a regular basis.

The registered manager has submitted notifications to CQC to tell us about events that had happened in the home. Since the beginning of 2014 notifications had been sent in to tell us about an expected death, when deprivation of liberty authorisations had been granted and where they needed to let us know about incidents of challenging behaviours. We have used this information to analyse how events had been handled.

Care plans were reviewed on a monthly basis by the nurses and more fully on a three monthly basis by the whole staff team. People and their families were included in the process. Any changes to their care and support needs were identified and the plans were amended.

All policies and procedures were kept under constant review and those policies we looked at all recorded when the next review date was.

The last service satisfaction survey was reported on in June 2014. The survey had resulted in both positive and negative comments about the service, the facilities and the staff team. An overall rating of 78% of respondents stated the service was 'excellent' or 'good'. The registered manager had an action plan in place to address the required improvements.

The home's complaints procedure was displayed in the main reception area. The registered manager had received 14 formal complaints in the previous 12 months and these had been handled following their formal complaints procedure. We looked at three electronic records that had been kept and these showed was actions had been taken and the outcome of the complaint. All 14 complaints had been resolved. We discussed with the registered manager the lessons learnt in respect of one particular complaint. The registered manager explained they would use information from any complaints to review their practice. The Dean had received 36 cards and letters of compliment in the last 12 months.

There was a programme of regular audits. Ten care plans were audited on a two monthly basis, management of controlled drugs was audited on a three monthly basis but stock levels were checked on a daily basis. Infection control audits were completed by the lead infection control

Good

Is the service well-led?

nurse and the management of medicines was audited by the group pharmacist on a six monthly basis. All audits resulted in a red-amber-green rating and an action plan being drawn up to remedy any shortfalls. There were measures in place to ensure all audits were completed when they were due and the identified improvements were made.