Rushcliffe Care Limited

Matthews Neurorehab Unit

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Matthews Neurorehab Unit is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Matthews Neurorehab Unit is located in the town of Loughborough, Leicestershire. It is a 38-bedded service for people with care and support needs arising from neurological conditions. The service included a multidisciplinary team which consisted of an occupational therapist, speech and language therapist, physiotherapists and nursing and support staff. Facilities included a physiotherapy gym and spa pool to help with people's rehabilitation. On the day of our inspection there were 35 people using the service.

We inspected Matthews Neurorehab Unit on 6 and 7 November 2018. The first day of our visit was unannounced. This meant the staff and the provider did not know we would be visiting.

At the last inspection in March 2016, the service was rated Good. At this inspection we found the service Required Improvement.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People had not always been safeguarded from abuse or avoidable harm as staff did not always follow the safeguarding procedures. This meant not all incidents had been reported to the relevant authorities or CQC as required by regulation.

There were not enough staff to meet people's needs in a caring, safe or timely manner.

The provider did not have suitable systems and processes in place to monitor the quality and safety of the service being provided

People did not always get their medicines as prescribed by their GP. The registered manager had made every effort to address this.

People's needs had been assessed prior to them moving into the service however the risks associated with people's care and support had not always been reviewed on a regular basis.

Not everyone had the relevant care plans in place. Those that did, not all had been reviewed in a timely manner to check they were still relevant.

People did not receive care that met all of their communication, social and psychological needs.

Not all of the staff team had received training on how to support people at the end of their life. We recommend this training be rolled out to all staff working at the service so they have the knowledge and understanding of how to support people appropriately at this time.

Whilst people were provided with a clean and comfortable place to live, some areas of the service were rather sparse and uninviting.

Appropriate pre-employment checks had been carried out on new members of staff to make sure they were safe and suitable to work there.

People had access to relevant healthcare services. They were support by the providers rehabilitation therapy team and received on-going healthcare support.

People's food and drink requirements had been assessed and a balanced diet was being provided. Records kept for people assessed as being at risk of not getting the food and drinks they needed to keep them well were, on the whole, up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

The staff team had received training in the prevention and control of infection and they understood their responsibilities around this. The necessary protective personal equipment was available and used.

There were arrangements in place to make sure action was taken and lessons learned when things went wrong to improve the service provided.

The staff team supported people to make decisions about their day to day care and support and they were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Decision specific capacity assessments had been completed to ensure any decision made on behalf of a person had been made in their best interest.

People told us the staff team were kind and caring and treated them with respect. Observations made during our visit confirmed this. People's consent was always obtained before their care and support were provided and the staff team supported people in the way they preferred.

The staff team felt supported by the registered manager and the senior team and told us there was always someone available to talk with should they need guidance or support.

People knew who to talk to if they had a concern of any kind. A formal complaints process was in place and this was displayed. Formal complaints received by the registered manager had been appropriately managed and resolved.

Relatives and friends were encouraged to visit and they told us the staff team made them welcome at all times.

Staff meetings and meetings for the people using the service had been held. These provided people with the opportunity to have a say and to be involved in how the service was run. Surveys had also been used to

gather people's feedback.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always kept safe from abuse or avoidable harm.

There were insufficient numbers of staff deployed to meet people's care and support in a safe or timely way.

Due to ordering issues, people did not always receive their medicines as prescribed by their GP.

The risks associated with people's care and support had not always been reviewed on a regular basis.

Lessons were learned when things went wrong.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Whilst people's care and support needs had been assessed, appropriate admissions had not always taken place.

The staff team had the skills and knowledge to be able to meet people's needs.

People's consent to their care and support was sought.

Decision specific capacity assessments had been carried out when required and the staff team understood the principles of the Mental Capacity Act 2005.

People were supported to maintain a balanced diet and were assisted to access health care services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staffing numbers meant the staff team had little time to care for people in a caring way or to focus on people's wellbeing.

The staff team were kind and caring and treated people with respect.

People were supported to make decisions about their care and support on a daily basis.

The staff team respected people's personal preferences and choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have care that met all of their communication and psychological needs.

Some people's care plans had yet to be developed. Those that had been developed were not always up to date or followed.

Not all of the staff team had received training on end of life care. People's wishes at end of life were being explored.

People who were able had been involved in the planning of their care with the support of their relatives.

There was a formal complaints process in place and people were reminded of what to do if they were unhappy about anything.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems used to check the quality of the service being provided were not always effective.

The Care Quality Commission had not always been notified of incidents and injuries that occurred or affected people using the service.

The staff team working at the service felt supported by the registered manager.

People were given the opportunity to share their thoughts on how the service was run.

Matthews Neurorehab Unit

Detailed findings

Background to this inspection

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

This inspection took place on 6 and 7 November 2018. The first day of our visit was unannounced. The inspection was carried out by three inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was people living with a learning disability and/or dementia.

Prior to our inspection, the provider had completed a Provider Information Return [PIR]. This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR before our visit and took this into account when we made judgements in this report. We also reviewed other information we held about the service such as notifications. These detail events which happened at the service that the provider is required to tell us about.

We contacted the health and social care commissioners who monitor the care and support of people receiving care from Matthews Neurorehab Unit to obtain their views of the care provided. We also contacted Healthwatch Leicestershire, the local consumer champion for people using adult social care services to see if they had any feedback about the service. We used this information to inform our inspection planning.

At the time of our inspection there were 35 people living at the service. We were able to speak with eight people living there, eight relatives and three visitors. We also spoke with the registered manager, two members of the senior management team and 20 members of the staff team.

We observed support being provided in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included four people's care plans. We also looked at associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for two nurses and two support workers and the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

People were not always safeguarded or protected from avoidable harm. Records showed the people using the service and members of the staff team had been affected by numerous episodes of both verbal and physical aggression in recent times and no appropriate action had been taken to address this. Records evidenced people using the service being hit, pushed and having cups thrown at them. Following one incident the completed incident record stated, "Threw a glass of water over [person] while asleep, [person] looked very scared." Staffing levels were not sufficient to enable the staff team to support people properly and keep them safe. The registered manager assured us they would increase the staffing levels to provide extra support for the staff team at this time.

Whilst the majority of people felt safe living at Matthews Neurorehab Unit one person did share their concerns regarding an incident of physical aggression they had experienced. One person told us, "I'm not frightened here and I feel safe." Though another explained, "[Person] keeps attacking me, punching me in the back of the head and trying to strangle me. I have told [registered manager]." There was no evidence of any action taken regarding this and the incident had not been reported to CQC.

The staff team were aware of their responsibilities for keeping people safe from abuse and avoidable harm and had received training in the safeguarding of adults. Whilst they had followed the providers safeguarding processes for recording concerns, these had not always been passed on or reported to the registered manager.

Whilst both the registered manager and the nurses we spoke with were aware of their responsibilities for keeping people safe, they did not follow their own safeguarding policy and procedure to raise a safeguarding concern with the relevant safeguarding authorities and the CQC. This was addressed following our visit with retrospective safeguarding referrals being made.

The provider did not have sufficient systems in place to ensure all safeguarding concerns were reported to the relevant authorities. These matters constituted a breach of Regulation 13, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

There were not enough staff to meet people's care and support needs. Low staffing levels within the service meant people were not always supported in a timely manner.

Staff told us there were not always enough staff on duty to enable them to meet people's physical and emotional needs. Staff comments included, "The current staffing levels are soul destroying. To go home at the end of the day and not be able to deliver our best, hurts." And, "We feel rushed and overworked. They [people using the service] are not getting the best from us, they deserve so much better. A lot are bored" And, "Don't know how to handle [person using the service] because we are short staffed we can't entertain them or keep an eye on them."

Records showed people were not always getting support in a timely manner because the staff team were busy supporting other people. Incident records showed people had to wait on some days between one, and three and a half hours for their care and support. A staff member recorded the times people had been delayed in receiving their care, "[Person] 1 hour 37 minutes, [person] 2 hours 12 minutes, [person] 1 hour 21 minutes, [person] 2 hours 26 minutes. Service users had delayed interventions including pad changes, washing and pressure relief. This is due to inadequate levels [of staff]." Another read, "The above residents received late interventions including, pressure relief, personal care and pad changes." People were at risk of pressure ulcers and a breakdown of their skin as a result of soiled clothing and pads due to the delays in planned care.

There was an electronic recording system in place to record in real time, when interventions such as the repositioning of people were carried out. Repositioning is carried out when people are at risk of causing damage to their skin. Records checked showed people's care plans were not always being followed with regarding to their need to be repositioned. For example, one person required to be repositioned two hourly during the day and three hourly during the night. On numerous occasions we identified in their records where they had gone four or five hours between being repositioned.

One person had been assessed as requiring two to one support from the staff team to keep themselves and others safe from behaviour that challenged. A staff member explained that whilst there were two staff members designated to support them throughout the day, when the staff members took their breaks they were not replaced. This meant there were times during the day when the person was only supported by one staff member. This put themselves and others at risk of altercations and physical abuse.

One of the people using the service told us, "I would like more time but they [staff] can't they're rushed off their feet." A relative explained, "There isn't enough staff other than to meet the basic daily needs."

Documentation including people's care plans was not always up to date. One staff member explained, "Care plans are not always completed because there is no time." On checking the electronic care plan system, it was noted some peoples care records had not been updated for between 33 days and 102 days.

It was identified staffing levels were not determined by the registered manager but by the senior management team. The registered manager explained they were in the process of collating data to take forward to the management team to put their case forward for more staff.

There were not enough staff deployed to meet people's physical, social and emotional needs. These matters constituted a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We identified concerns with regards to people's medicines because people had not always received their medicines as prescribed. Complications related to the medicine ordering process, and liaison with the GP practice meant the service did always receive people's medicines from the pharmacist in a timely way to ensure people had their medicines administered as per their prescription. On the day of our visit we found there were a number of people whose medicines were out of stock. This included one person who had not received an antipsychotic medicine for a total of five days and another who had not received an antipsychotic medicine for four days. A third person had not received their medicine for hypertension (high blood pressure) for eight days and a fourth person had not received their regular pain relief medicine for four days, though they had been offered their 'as required' pain relief medicines. The registered manager explained staff had not observed any changes in these people's health during the time they were without their medicines.

Despite the registered manager, deputy manager and clinical leads best efforts, issues remained with regards to the availability of people's medicines. The registered manager explained there was a meeting planned with key stakeholders to try and address this issue and find a solution.

Dressings were changed and topical preparations applied during people's personal care. Support workers recorded this on the person's care records via hand held devices at the point of contact with the person using the service. As the care record was separate to the medicine administration record (MAR), The MAR had not always been signed to demonstrate these actions had been carried out. We observed one MAR where a dressing, due to be changed at least every three days had not been signed for or changed as planned. This meant the registered manager would have to check the care record to ascertain whether or not this had been done as per prescription. The non-signing of medicine records can be deemed a medication error.

The temperature of the ground floor medicine room was recorded as 25 degrees. This had only recently been opened as a medicine room. We found food supplements that were required to be stored below 25 degrees were being stored there. The registered manager explained the person prescribed these supplements no longer required them and they would be disposed of.

We observed the deputy manager carry out the medicine round at lunchtime. They wore a red tabard so people would know they were administering medicines and shouldn't be disturbed. This however did not always stop members of the staff team interrupting them and the deputy manager was seen being disturbed by members of the staff team during their medicine round. Disturbances during the administering of medicines increases the risk of mistakes occurring.

The registered manager explained the registered nurses were expected to complete weekly medication management audits and they undertook a monthly audit. However, we were informed the weekly audits had not been completed for the last three weeks. The registered manager was in the process of looking into this as they could not give us a reason for this oversight at the time of the inspection.

Risks associated with people's care and support had not always been assessed when they had first moved into the service. For a person identified at risk of choking, a speech and language (SALT) assessment had yet to be completed. The registered manager explained they had recently been referred to their speech and language therapist for this assessment to be carried out. Where risks had been assessed, such as risks associated with dehydration and falls, these had not always been reviewed in a timely manner.

Regular safety checks had been carried out on the environment and on the equipment used. Checks had been carried out on the hot water at the service to ensure it was delivered at a safe temperature and yearly checks had been carried out on the portable appliances used, to check they remained in good condition. The staff team were aware of the procedure to follow in the event of a fire and personal emergency evacuation plans were in place showing how each individual must be assisted in the event of an emergency.

The staff team had received training in infection control and followed best practice guidance in preventing the spread of infection. We saw personal protective equipment such as gloves and aprons were readily available and these were used by the staff team throughout our visit.

The service had a five star food hygiene rating from the local authority. Five is the highest rating awarded by the Food Standards Agency (FSA). This showed the service demonstrated good food hygiene standards.

The provider's recruitment process had been followed when new staff members had been employed.

Previous employment had been explored, references had been collected and a check with the Disclosure and Barring Service (DBS) had been carried out. A DBS check provided information as to whether someone was suitable to work at this service. We did note in one person's file, a delay in the obtaining of their DBS. This was discussed with the registered manager who immediately investigated the reason for this and assured us this person had not worked unsupervised. For the nurses working at the service, a check with the Nursing and Midwifery Council (NMC) had also been carried out to make sure they had an up to date professional registration. Nurses can only practice as nurses if they are registered with the NMC.

Systems were in place to audit accidents and incidents that occurred at the service. The registered manager explained they audited records each month to look for patterns and took the necessary action when patterns emerged. Recent incidents that occurred at the service had yet to be audited.

The staff team were encouraged to report incidents that happened at the service and the registered manager ensured lessons were learned and improvements were made when things went wrong. For example, following a breakdown in communication, the registered manager had identified that it was essential to discuss at the earliest point possible during the assessment process, the person's and family's expectations regarding their rehabilitation potential. This prompted improved communication systems between the staff team and the people using the service and their family members.

Requires Improvement

Is the service effective?

Our findings

Whilst people's individual and diverse needs had been assessed prior to them moving into the service, it was evident that appropriate placements had not always been made. The provider employed a bed manager whose role it was to carry out assessments on behalf of the registered manager. This meant the registered manager was not able to influence or make an informed decision as to the appropriateness of the people being assessed, prior to them moving into the service.

We discussed the suitability of recent admissions to the service with the registered manager. It was evident the staff team were struggling to meet their care and support needs and their presence was having a detrimental impact on the other people living there. The registered manager explained a review of the one of the people's placement had already taken place and a further review was imminent to ensure their needs could be properly met by the staff team.

The staff team were supported by a range of health care specialists and care, treatment and support was provided in line with national guidance and best practice guidelines. The service employed a dedicated therapy team, including physiotherapists, a speech and language therapist, an occupational therapist and a social worker to support people with their rehabilitation. This enabled the staff team to support people effectively and in line with best practice. A message from a relative stated, "When [person] came to Matthews we just wanted to see them walk out. Not only can they walk now with a walking aid, they can climb stairs and balance." One of the people using the service explained, "I exercise in the gym when they give it to me [time slot]. I would do it twice a day [in the gym] if I could. I want to walk. They [staff] do walk me and spend time with me." Another told us, "I go to the gym and do all sorts of exercises. I try to do more. I see the physios and OT's often enough. They are kind and gentle."

People had access to external healthcare services and received on-going healthcare support. The staff team were observant to changes in people's health and when concerns had been raised, support from the relevant healthcare professionals such as the GP had been sought in a timely manner. Weekly multi-disciplinary team meetings were also held to discuss the care and support needs of the people using the service.

The staff team worked together within the service and with external agencies to provide effective care. This included providing key information to medical staff when people were transferred into hospital so their needs could continue to be met.

People received care and support from a staff team that had the overall skills and knowledge to meet their individual needs. The staff team had received a comprehensive four-day induction into the service when they first started working there and relevant training had been provided. This included training in health and safety, the safeguarding of adults, moving and handling and positive behaviour and dignity training. We did note some staff members training was out of date. The registered manager explained the provider's training department was aware of this and a programme had been devised to provide the required training between now and December 2018. A copy of the programme was seen during our visit. The opportunity to work

alongside experienced staff members was also provided to enable new support workers the opportunity to understand their role and the expectations of the registered manager.

Nurses working at the service had been supported by the registered manager to meet their requirements for revalidation and maintain their professional registration with the NMC.

The staff team were supported through supervision and appraisal and they told us they felt supported by the registered manager. One explained, "The pastoral care from [registered manager] has been fantastic." Another told us, "[Registered manager] is very supportive and helps with problem solving."

People were supported to maintain a healthy balanced diet and people told us the meals served at Matthews Neurorehab Unit were good. One of the people using the service explained, "The food is alright, better than my missus's cooking anyway." A relative told us, "The food looks nice but one day [person] had two triangle sandwiches and the next day a large meal. The portion sizes seem to vary. I've not been invited to have a meal but I do have cups of tea or coffee."

Advice on how to meet people's nutrition and hydration needs was available from the in-house speech and language therapy team and outside professionals. We saw food and fluid charts were in place for those who were at risk of dehydration or malnutrition. These had been completed appropriately. Where people were unable to maintain adequate nutrition through oral intake, a percutaneous endoscopic gastrostomy PEG) tube was used to provide a specialised liquid food This was maintained by the staff team working at the service to ensure people received the nutrition they needed.

The chef had information about people's dietary needs. They explained the staff team informed them of people's nutritional requirements. They knew about the requirements for people who needed a soft or pureed diet and for people who lived with allergies. They worked well with healthcare professionals and followed their specialist advice with regard to people's food intake. For example, following an assessment by the providers speech and language therapist, one person was moved from a pureed diet to a fork mashable diet.

People's dining experience on the days of our visit were varied. At times we saw limited interaction between the people using the service and the staff team with no attempt to make this a more social occasion. At other times we observed more interaction and general chatting about local news. People were offered a choice of meal at mealtimes and were supported by the staff team in a way they preferred. We did note the dining room was rather stark and tables were not set to help cue the people using the service into the dining experience.

Whilst people's needs were met by the adaptation, design and decoration of the premises, some areas of the service were rather sparse and tired looking. Lounges and dining rooms felt cold and impersonal however, we did note areas of the service were being painted at the time of our inspection. People had access to suitable spaces. There were spaces available for people to meet with others or to simply be alone. A family room had been created since our last visit providing people with a space where they could meet their family and friends in private.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager was working within the principles of the MCA. The staff team had received training in the MCA and DoLS and they understood their responsibilities within this.

People who were able were encouraged and supported to make decisions about their care and support whenever possible. During our visit we saw people choosing how to spend their day, whether to attend the group activity offered and what to eat and drink. One person told us, "I can go to bed when I want to and get up when I want to, within reason."

Requires Improvement

Is the service caring?

Our findings

Whilst people told us the staff team were kind and caring, staffing numbers determined by the provider meant people could not be cared for well. The staff team were focused on the task in hand and had little time to focus on people's wellbeing. The staff team did not always have the time to recognise and give people the compassionate support they needed or have the time to sit and talk with people for a meaningful length of time.

One of the people using the service explained, "They [staff] are kind and are good at looking after me." Another explained, "They [staff] are very good to me, they listen, I can't complain."

Relatives we spoke with agreed their family members were treated in a caring manner. One explained, "They [staff] are definitely caring and treat [person] with dignity because I hear how they speak to them and ask them first, like, 'Can I?' and 'How can I?'."

Whilst speaking with one person it became evident they were cold. We found a member of staff to assist them. The staff member supported them in a very kind and gentle way and treated them with respect throughout.

We observed positive verbal and non-verbal communication between the staff team and the people using the service and the staff team showed consideration for the people living there. We saw genuine, kind and warm interactions between the staff team and the people using the service. However, we did note at times there appeared to be more engagement with the people who were able to interact back, either verbally or through assisted technology, than with those who were unable to engage.

Staff respected people's privacy, staff were seen knocking on people's bedroom doors before entering. They spoke about people with respect and with affection.

The staff team were knowledgeable about the people they were supporting. They knew people's preferred routines and the relatives and friends who were important to them. Staff knew people's likes and dislikes and understood the importance of respecting people's religious beliefs and their personal preferences and choices. One member of staff told us how one person actively disliked them, they therefore made sure they did not support that person so as not to antagonise them.

People were encouraged to maintain relationships that were important to them. Staff had received training in equality and diversity and respected people's wishes in accordance with the protected characteristics of the Equality Act. The staff team supported relatives to continue to be involved in their family members care. A relative explained, "I visit every day." We observed them being involved in the care of their relative and this involvement was included in the person's care plan. The staff team respected people's cultural diversity, for example when family joined one person, time and space was given to them to observe their ceremonies and prayers.

Advocacy services were made available to people who were unable to make decisions regarding their care and support, either by themselves or with the help of a family member. This meant people had access to someone who could support them and speak up on their behalf if they needed it.

Relatives were made welcome and were able to visit at any time, though mealtimes were discouraged to help protect meal times from disruption. One relative explained, "The staff are very polite and talk to me. I would give here four and a half out of five because I always feel welcome and they are polite to [person]." The service was busy with many visitors visiting during the inspection. Staff were seen welcoming of visitors to the service.

Requires Improvement

Is the service responsive?

Our findings

The Accessible Information Standard (AIS) is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

Although the provider understood their responsibility to comply with the AIS and was able to access information regarding the service in different formats to meet people's diverse needs, these were not always implemented.

The in-house therapy team supported people who were unable to verbally communicate with the use of aids and adaptations. These included electronic keyboard and screen devices which enabled people to communicate with the staff team and their relatives. We did note during our visit not all of these devices were in working order. For example, one person was reliant on a piece of assisted technology to enable them to communicate and also retain a degree of independence. During the medicine round, it became apparent that the device required more batteries, which the registered nurse promptly arranged.

With the exception of televisions, there appeared to be limited sensory stimulation such as lighting, music, sounds, and smells available to the people who spent the majority of their time in bed.

There was an activities coordinator at the service who worked hard to try to provide people with activities they enjoyed. Regular group sessions were offered including a news group, book club and film afternoons, though a lot of people preferred to stay in their rooms. They explained for people who stayed in their rooms one to one sessions were offered when possible. They told us, "A lot of people like to be read too, one person goes on regular shopping trips and one person likes to cook. We have developed a 'getting to know you' section where we have built up a picture of the person from family and friends. We've built up an activities and social history folder as well which staff look at." The getting to know you form provided staff with an insight into the person's past history and included information on the hobbies and interests they enjoyed before moving into the service. It was evident when talking to the staff team that they were aware of people's individual likes and interests.

People thoughts on how they spent their time at Matthews Neurorehab Unit varied. Some people were happy with what was offered, others felt bored at times. One person explained, "I do get bored. All I do is sit." A relative told us, "[Person] gets bored, there's not enough to do. They want to walk and walk and walk. [Person] came here for more physio but only has 1 hour a week. They [management team] are talking about this though."

Staff told us they felt people's social needs were not always being met. One explained, "We don't feel the residents have much to do. They will have baking and game mornings, but a lot just want to stay in their room. In the summer we went for a lot of walks. We have tried to arrange things but it doesn't work out. We wanted to do a BBQ, but couldn't because of health and hygiene. We wanted to do a boat trip and picnic but that didn't happen. We would like to see people do a bit more. We feel that it would encourage them if they

were in a good frame of mind. Some people went to the cinema and they really loved it. It is free, but it takes staff off the floor. We have tried to support on our day off. It is lovely to see their faces. We don't always get time to sit and have a chat. Sometimes we have time in the afternoon, but not often."

People did not receive care that met all of their communication, social and psychological needs. These matters constituted a breach of Regulation 9, person centred care

The registered manager had introduced as part of the assessment process the development of a discharge plan for everyone new to the service. One staff member explained, "Since [registered manager] took over, people now have discharge plans. At assessment we are asking them and their family what their aims and goals and aspirations are. [Registered manager] is working hard for discharge from day one." From the initial assessments, care plans had been developed though not always reviewed in a timely manner.

People did not always receive their care as planned. Care plans covered areas of people's care and support including the support they required with mobility, nutrition and hydration, skin care and the personal care they required. Care plans checked varied in content. Whilst some were comprehensive and detailed, others were basic in content and not fully completed. For example, one person's blood pressure care plan stated their blood pressure should be checked daily because of their health condition. Their wound management plan stated their vital signs, including their blood pressure, should be taken daily. When we checked their records, both paper records and electronic records, we found there was no record of their blood pressure being checked between the 22 October 2018 and 27 October 2018 or on the 1 November 2018 or the 4 November 2018. This person was at risk of a delay in staff seeking medical treatment as staff did not take daily vital signs that could indicate their health was deteriorating.

In the care plan belonging to a person with behaviour that challenged others, the objective in their emotional wellbeing plan was, 'For all staff to be aware of the crisis development model and adhere to its principles'. (The crisis development model allows you to look at challenging situations differently and act to affect them positively). Not all of the staff members we spoke with were aware of this model or its principles. Not all of the staff had received training in managing people with behaviour that challenged others.

People had been involved in the planning of their care whenever possible with the support of their relatives. One person explained a member of the staff team had visited them while they were in hospital in order to carry out an assessment of their needs. Initial assessments were included in the documentation checked.

Staff explained when a new person came to live at Matthews Neurorehab Unit, they were told a few days before their arrival of their care and support needs. They explained this was followed up by a briefing on the morning of the person's arrival and then it was for the staff team to read the person's care plan.

People's care plans included information on how best to communicate with them. For example, one person's communication plan stated, 'Please knock before you enter my room and make your presence known but also be aware I do respond to loud noises in a negative manner. Always speak to me directly face to face, this will help us both pick up on individual cues. Please ensure you have gained my attention at the beginning of interactions. This can usually be achieved by saying my name, and then gaining eye contact'.

A formal complaints process was in place and people we spoke with knew who to talk to if they were unhappy about anything. One of the people using the service told us, "I would tell them [staff] if I needed a moan." A relative explained, "I did make a complaint because there wasn't enough staff and [person] had been left in bed. This resulted in them [management] getting in agency staff."

Whilst the staff training matrix showed most of the staff team had received training on supporting people at the end of their life. The staff members on duty during our visit had not. One explained, "When a person is dying a nurse and a care worker would be present." Two staff said they were initially scared when they first had to deal with this, but now they felt more confident.

We recommend end of life training be rolled out to all staff working at the service to enable them to feel comfortable and confident in supporting people at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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 registered manager had systems in place to monitor the quality and safety of the service though these had not identified the shortfalls found during our visit. For example, the monthly care plan audits had not picked up that some care plans had been completed or reviewed on a regular basis. The upkeep and use of assisted technology hadn't been properly monitored. Daily records showed that people had not always been supported in line with their care plan, the quality audits had not identified this. Medicine audits had not always been completed as required and the monitoring of staffing levels had not been effective to ensure appropriate numbers of staff were deployed to meet people's care and support in a safe and timely.

The registered manager was aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. However, because reporting processes had not been followed, acts of abuse that had occurred at the service had not been highlighted to the registered manager and the appropriate notifications had not been submitted to the CQC as required by regulation.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

People we spoke with told us they felt the service was well managed and the staff team were friendly and approachable. A relative told us, "The manager is approachable. There is always someone I can talk to." Another stated, "I haven't met the registered manager but my [family] have. The conversations they have had have been helpful."

Staff members felt supported and valued by the registered manager. They told us there was always someone available they could talk to if needed. One staff member told us, "They [registered manager and the senior team] definitely listen, they are very good." Another explained, "I like [registered manager], I think he is a good manager, but has so many things from above so makes it difficult. The residents love him and he's really understanding. Never seen a case manager get hands on like [registered manager] does. He knows what the unit needs, but the big bosses are saying no, no, no. As a manager I think he is a good manager."

The staff team told us there was a good team ethos at the service. They told us both support workers and nursing staff worked well together to help provide the care and support people required. During our inspection it was evident staff were comfortable interacting with the registered manager and a positive and open working atmosphere was present. The staff members we spoke with were aware of their roles and responsibility, and understood what was expected of them.

People and their relatives had been given the opportunity to share their thoughts of the service being provided. This was through regular meetings and informal chats. The registered manager had also used surveys to gather people's views of the service provided. These had been completed by the people using the service and their relatives. Following the return of the most recent surveys, a 'You Said…., We Did' action plan had been produced and this was displayed for people's information. For example, people had stated there were not enough quiet places to sit. Following this a family room had been created for people's use where they could sit with family and friends in private.

Staff members were given the opportunity to share their thoughts on the service and be involved in how the service was run. This was through formal staff meetings, supervisions, daily handovers and day to day conversations with the management team.

The registered manager worked openly with stakeholders and other agencies. This included liaising with social work teams and other professionals when appropriate, to ensure people's ongoing health and welfare.

The registered manager was aware of their responsibility to have on display the rating from their last inspection. We saw the rating was clearly on display on the provider's website and within the service. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgements.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that met all of their communication, social and psychological needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected from the risk of abuse or avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems used to monitor the service were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff deployed to support people in a caring, safe and timely manner.