

Brighton and Hove City Council

Brighton & Hove City Council - Knoll House

Inspection report

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Date of inspection visit:
26 September 2016

Date of publication:
15 November 2016

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 ●

Summary of findings

Overall summary

This inspection took place on 26 September 2016 and was unannounced.

Knoll House provides personal care and support for up to 20 people. Care and support is provided to adults, but predominantly to people over 65 years of age. It provides short-term rehabilitation for a period of usually two to three weeks, but can be for up to six weeks. People primarily stay at Knoll House following discharge from hospital, or to prevent an unnecessary admission to hospital. The ethos of Knoll House is to support people to regain their independence and promote independent living skills. Help provided at Knoll House included assistance with personal care, mobility, kitchen assessments, including meal and hot drink preparation, mobility practice, home and/or access visits to assess people's home environment, stoma education and catheter care.

The short-term rehabilitation is a joint partnership between Brighton and Hove City Council and the Sussex Community NHS Trust who work together to provide co-ordinated care. Consultants for elderly care, GPs and a community mental health nurse visit the service. On the premises people receive support from a social work team, social care staff, medical and nursing staff, physiotherapy and occupational therapy staff. There are a high level of admissions and discharges due to the short-term nature of the service, and there are no long term placements. There were 18 people living in the service on the day of our inspection.

Knoll House is a two story building with a passenger lift for level access throughout the building. All the bedrooms are single occupancy with ensuite facilities. All lounges have kitchen and dining facilities. People are also able to use a conservatory and landscaped garden area. A separate kitchen and gym area is available for people to be supported to work towards their agreed goals for independence.

There was a registered manager for 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection was carried out on 23 September 2015. We found a number of areas of practice which required improvement. This was in relation to not all the care staff had received training or guidance on Deprivation of Liberty Safeguards(DoLS), and were not aware who had a DoLS agreed. Where people had been assessed at risk of developing pressure sores, the equipment identified to be used had not been regularly checked to ensure it remained at the right setting to meet people's individual needs. Medicines were kept securely and within their recommended temperature ranges, except for one medicine awaiting disposal that was required by law to be stored in a specific way. Whilst the effectiveness of medicines were appropriately monitored and relevant care plans were available to support the management of most people who lived in the service, the care plan and medicines administration record (MAR) used to record the administration of medicines for one person were not consistent. Some people had food and fluid intake charts being completed. However, records were not all accurately maintained to detail what people ate or

drunk, to fully inform the nursing staff. Not all the care staff demonstrated knowledge of people's individual dietary requirements. The information which had been detailed in individual care plans for staff to follow was variable, had not always been fully completed and did not always give clear guidance for care staff to follow. Where care had changed it was not always possible to identify when this had occurred and the rationale for the change. People also told us they would have liked more opportunities to join in social activities. The provider drew up an action plan as to how they would address these issues. We looked at the improvements made as part of this inspection. At this inspection we found the provider had followed their action plan, improvements had been made and the regulations were now being met.

The service was going through a significant period of review, where the provider and local stakeholders were looking at the service provision, what was needed and how the service would best be provided in the future. Staff told us this had led to a number of staff changes since the last inspection.

People told us they felt safe. They knew who they could talk with if they had any concerns. They felt they could raise concerns and they would be listened to. People were supported by care staff who were trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the registered manager.

The service was clean. One person told us, "Excellent housekeeping." Another person told us, "It is extremely clean and the housekeepers are nice and chatty." There was a maintenance programme in place which ensured repairs were carried out in a timely way. Regular checks had been completed to ensure equipment and services were in good working order.

People and their relatives told us there were adequate care staff on duty to meet their care and support needs. One person told us, "When I press the bell for help I've never been made to feel a nuisance." Senior staff monitored people's dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training records were kept up-to-date, plans were in place to promote good practice and develop the knowledge and skills of staff.

People's individual care and support needs were assessed before they moved into the service. People had a care and support plan and risk assessments in place. These were detailed and gave clear guidance for care staff to follow. Charts in place to monitor people's food and fluid intake and to ensure that pressure relieving equipment was set to meet people's individual requirements had been consistently completed. Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They felt they knew people's care and support needs and were kept informed of any changes. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. One person told us, "I can get up when I want, I've even been asked if I want a lie in." Comments received by staff in the service this year included, 'The care and help from Knoll House was great. They helped show me how to cope with things like holding a kettle and live independently,' and 'For all your care and commitment and help. I so appreciated everything. I fly today.'

People told us they had felt involved in making decisions about their care and treatment and felt listened to. Comments received by staff in the service this year included, 'You have all looked after me so well that I have no words to thank you enough. A simple 'thank you' seems inadequate and you all have been absolutely great.' Staff were kind and caring. Comments received during the inspection included, "There is nothing else we could ask for" and "Their really helpful and friendly and share information."

People were treated with respect and dignity by the staff, and were spoken with and supported in a sensitive, respectful and professional manner. People's healthcare needs were monitored and they had access to health care professionals when needed. People spoke well about the support they had received as part of their rehabilitation. A relative told us, "This is the best continuation of care that we have experienced without doubt." Comments received by staff in the service this year included, ' So much appreciate all the professionalism, patience and dedication but above all the 100% smiling faces and atmosphere of Knoll House. This is something I know you will take forward 'and' Thank you for your kindness and support helping my mum on her next leg of life's journey.'

People's nutritional needs had been assessed and they had a selection of choices of dishes to select from at each meal. People said the food was good and plentiful. Staff told us that an individual's dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences.

People and their representatives were asked to complete a satisfaction questionnaire at the end of their stay. We could see people were able to comment on and be involved with the service provided to influence service delivery. The registered manager told us that senior staff carried out a range of internal audits, and records confirmed this. The registered manager also told us that they operated an 'open door policy' so people living in the service, staff and relatives could discuss any issues they may have.

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 cared for by staff been recruited through safe recruitment procedures. Staffing levels were monitored to ensure there were enough staff to meet people's care needs.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. Equipment identified to be used had been checked and maintained to meet people's individual requirements and to fully protect people.

Medicines were stored appropriately. There was guidance for care staff to follow when administering medicines 'as and when'(PRN).

Is the service effective?

Good ●

The service was effective.

Staff were aware of their responsibilities from the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) Where people lacked capacity to make decisions about their care and treatment this had been considered in their best interests.

Staff had a good understanding of people's care and support needs. People were supported by staff that had the necessary skills and knowledge.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals when they needed.

Is the service caring?

Good ●

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Good ●

The service was responsive.

People had been assessed and their care and support needs identified. Detailed care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

People were supported as part of their rehabilitation programme to help them to return home. People could take part in recreational activities in the service. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Good ●

The service was well led.

Quality assurance was used to monitor to help improve standards of service delivery.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of the service was approachable and very supportive.

People were able to comment on and be involved with the service provided to influence service delivery.

Systems were in place to ensure accidents and incidents were reported and acted upon.

Brighton & Hove City Council - Knoll House

Detailed findings

Background to this inspection

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

This inspection took place on 26 September 2016 and was unannounced.

The inspection team consisted of two inspectors, 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. The expert by experience helped us to get feedback from people being supported and their relatives.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we had received. This helped us to plan our inspection. We did not request on this occasion the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received information from the Clinical Commissioning Team (CCG). Following our inspection, we received feedback from a health care professional about their experiences of the service provided.

We spoke with the registered manager, the deputy manager, a registered general nurse (RGN), a GP, a pharmacist and specialist pharmacy technician, seven care staff, and a cook. We observed the care and support provided in the communal areas, and the mealtime experience for people over lunchtime. We spoke with 11 people who were living in the service and five relatives.

We looked around the service in general, including the communal areas, and people's bedrooms. We sat in

on a staff handover and observed medicines being administered. As part of our inspection we looked in detail at the care provided to six people, and we reviewed their care and support plans or their medicine administration. We looked at menus and records of meals provided, medicines administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and five staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

We last inspected this service on 23 September 2015, when the overall rating for the service was Requires Improvement.

Is the service safe?

Our findings

People told us they felt safe and were well treated in Knoll House. People and their relatives told us there were adequate care staff on duty to meet their care needs. One person told us, "The carers respond to the bell well, I press it all the time." A relative told us, "There are loads of care staff." Feedback from the service's own quality assurance questionnaires from between April and September 2016 detailed 100% of respondents agreed when asked, 'I felt very safe.' One person commented, 'I felt very safe and in good hands.'

At the last inspection on 23 September 2015 we found areas of practice in need of improvement. This was because where people had been assessed to be at a risk of skin breakdown (pressure sores) an air mattress (inflatable mattress which could protect people from the risk of pressure damage) had been provided. However, records did not evidence there had been regular checks of the equipment to ensure they were on the right setting for the individual needs of the person. Medicines were kept securely and within their recommended temperature ranges, except for one medicine awaiting disposal that was required by law to be stored in a specific way. Whilst the effectiveness of medicines were appropriately monitored and relevant care plans were available to support the management of most people who lived in the service, the care plan and medicines administration record (MAR) used to record the administration of medicines for one person were not consistent. Guidance as to why their medicines should be taken was not the same on both documents to ensure a consistent approach when administered. During this inspection, we found improvements had been made and issues identified had been rectified.

To support people to be independent, people had individual assessments of potential risks to their health and welfare. Individual risk assessments completed included falls, nutrition, pressure area care and manual handling which were reviewed regularly. Staff told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. Where people had been assessed to be at a risk of skin breakdown an air mattress had been provided. We were informed by staff that air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. We found that the records of these checks to show that these had been maintained had been regularly completed.

We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One member of staff told us, "We don't restrict people. The whole point of people being here is to gain independence." Another member of staff told us, "I think it's important to understand why we're here. Some people who come here have been told they're going to a hotel. It's the opposite really. We're here to help them get their independence back and that means a degree of risk, which we manage. But staff here don't do things for people just for the sake of looking busy. If someone can do things for themselves, then they will." Our observations on the day confirmed this.

People told us they got their medicines in a timely way. One person told us, "I get my medicines when I need them, I'm not sure what they all are, but I just take them, there are a lot." Another person told us, "My medicines are always on time." People were encouraged to 'self-medicate' where possible within the risk

management process. Two people at the service self-medicated, that is managed their medicines independently. We noted each person's ability to manage had been assessed and there were ongoing assessments to ensure continued competency. These people had access to the medicine cabinets in their rooms; staff regularly checked to ensure stock balance was correct.

We looked at the management of medicines. There were appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines. Medicines were kept securely and within their recommended temperature ranges. Medicines requiring refrigeration were stored in a refrigerator, which was not used for any other purpose. The temperature of the refrigerator and the room in which it was housed was monitored daily to ensure the correct storage temperatures for medicines. The care staff were trained in the administration of medicines and had their competency regularly checked. They told us the system for medicines administration worked well in the service. Systems were in place to ensure repeat medicines were ordered in a timely way. MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as Warfarin. Records detailed how people preferred to have their medicines administered to ensure a consistent approach. Where people took medicines on an 'as and when' basis (PRN) there was guidance in place for staff to follow to ensure this was administered correctly. One person told us they felt able to ask for pain killers before they had their 'gym session' with the physiotherapist. Regular checks were completed during each staff shift to ensure people received their medicines as prescribed. This also helped to identify any discrepancies or errors and ensured they were investigated accordingly. We observed one member of staff administer some medicines. They informed the person why they had come to see them and what the tablets they were being given were for. The person told us they had been at Knoll House for one week and was very happy with the way their medicines were dispensed. They told us, "There's no mucking about." There were regular visits from a pharmacist employed by the Sussex Community NHS Trust. We were also shown the most recent medication audit undertaken by staff at the service and the actions they were intending to take to rectify any concerns.

We looked around the building and found the premises were well maintained. The environment was clean and spacious, which allowed people to move around freely without risk of harm. Regular tests and checks were completed on essential safety equipment, such as emergency lighting, the fire alarm system and fire extinguishers. Staff were able to access a maintenance department for the servicing and maintenance of the building and equipment. Records confirmed that any faults were repaired promptly. Staff told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, such as flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for help and support.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of, and followed, the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen, and therefore it could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One member of staff told us, "We get yearly updates on this and there are staff we can ask, like the manager or social workers." Another member of staff told us, "I know the manager would do something if abuse was suspected."

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

People told us there were enough staff and they got the help and support they wanted. On the day of our inspection there were sufficient staff on duty to meet people's needs. Staff had time to spend talking with people and supported them in an unrushed manner. All rooms had call bells and people could also wear a pendant which they could press to summon assistance if they required urgent attention. People told us when they called for assistance they received help in a timely way. One person told us, "They answer the buzzer well and respond quickly at night." Another person told us, "All the carers are nice and they come straight away if I press the bell." Staff told us how staffing was managed to make sure people were kept safe. A sample of the records kept of when staff had been on duty and how many showed that the minimum staffing level was adhered to. In addition to the care staff employed at the service the trust staff provided the specialist nursing and rehabilitation services. Registered nurses from the Sussex Community NHS Trust worked in the service between 8.00 am and 8.00 pm seven days a week. Outside of these hours the community out of hour's service would be called if required. Dedicated doctors, physiotherapists, occupational therapists, and social workers from the intermediate care scheme provided care and support to people who used the service. A team of ancillary workers who covered administration, domestic duties, maintenance, and catering services supported all the care staff in the service.

The staff showed us the dependency tool they used to help ensure that there were adequate staff planned to be on duty. Senior staff regularly worked in the service to keep up-to-date with people's care and support needs, which helped them check there were adequate staff on duty. We asked staff about staffing levels at the service. Care staff told us generally there was enough staff to meet people's care and support needs. Where possible staff were requested who had previously worked in the service and had an understanding of how the service was run. One member of staff told us, "I think it's okay most of the time."

Senior staff had the support of the provider's human resources department when recruiting staff. They told us that all new staff had been through a robust recruitment procedure to meet the requirements of the provider's policies and procedures. Staff recruitment files we looked at demonstrated a safe recruitment process had been followed. Where external staff were recruited to work in the service an application form was completed, an interview and two written references and a criminal records check were requested.

Is the service effective?

Our findings

People told us they felt the care was good, and the choice and food provided was very good. One person told us, "The food is marvellous." Another person told us, "The food here is very nice, I'm given a choice of two main dishes and I can eat it where I want." Comments received by staff in the service this year included, 'I would like to say that during my stay at Knoll House I found the staff caring and knowledgeable and my room and bathroom were excellent. What's more you have an excellent chef. I arrived around lunchtime and was served homemade strawberry mousse made with real fruit. Other meals maintained a high standard.'

At the last inspection on 23 September 2015 we found areas of practice in need of improvement. This was because there was little evidence in people's care and support plan that their consent had been agreed to the care provided and this had been inconsistently completed. Where a DoLS had been agreed this had not been documented in the care and support plan. DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. Care staff were not all clear who had a DoLS in place, or if there were any actions they had to follow to support people where an application had been agreed. Additionally, people's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. Some people had food and fluid intake charts being completed. However, records were not all accurately maintained to detail what people had eaten or drunk to fully inform the nursing staff. Not all the care staff demonstrated knowledge of people's individual dietary requirements. During this inspection, we found improvements had been made and issues identified had been rectified.

Care staff demonstrated an understanding and there were clear policies around the Mental Capacity Act 2005 (MCA) and DoLS. 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 when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. People told us they were asked for their consent before any care and treatment was provided. Care staff told us they had completed or were due to complete this training and all had a good understanding of the need for people to give consent to any care or treatment to be provided. Where possible people had signed to give their consent to the care and treatment agreed to be provided. One member of staff told us, "If people have mental capacity it's up to them what they do." Another member of staff told us, "A lot of the people who come here make their own decisions. If they couldn't, we'd work with their families to make sure things were done in their best interests." We could see how DoLS had been considered in the service and applications had been made. The senior staff members we spoke with were knowledgeable about those who were currently either subject to DoLS or waiting authorisation.

People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed

as part of the admissions process. For example, for one person detailed in their care plan was, 'Choking/coughing. To be in the dining room for all meals. A soft, moist diet, open cup and food cut up and to be observed.' Some people had food and fluid intake charts to monitor if they had sufficient food and fluid intake. We were told that the nursing staff on duty were responsible for overseeing these. Records were accurately maintained to detail what people ate or drank to fully inform the nursing staff and enable them to assess if people had adequate food and fluid to maintain their wellbeing. One relative told us their relative was on a 30 minute watch to prompt their eating and drinking. They said, "The staff have been so kind trying to encourage my dad to eat." People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight.

People spoke well of the food provided and staff came in advance to ask them what they would like to eat. The lunchtime meal was dished out in the dining room to people's individual requirements and staff demonstrated an awareness of people's individual dietary needs. Comments received from people included, "The food is gorgeous," "If I didn't like it they would bring me something else," and "The food is very good, I'm offered a choice." The cook told us there was a rotating menu, which was based on people's likes and dislikes. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the cook. The cook showed us they had information available on the dietary requirements and likes and dislikes of each person. This showed us that staff were aware of individual's preferences, needs and nutritional requirements. Feedback from the service's own quality assurance questionnaires from between April and September 2016 detailed 92% of respondents agreed when asked, 'I was able to choose from a range of food that I liked, and to have as much as I wanted.' A 100% of respondents agreed when asked, 'I was able to choose food that suited my individual needs,' and 'I was able to choose where I ate.' Comments received included, 'The food was exceptionally good and they catered for my needs (as a vegetarian) very well,' 'No complaints the food very good,' and 'I am a vegetarian and had a very good vegetarian alternative every day. I thought the standard of food was altogether very good.'

People told us they had a choice of either eating their meals in their room or in one of the dining rooms. One person told us, "I'm a solitary person and I prefer my food in my room, this is respected." Another person told us, "I have stayed in my room for meals so far as I've only been here a few days, but now I'm getting about a bit better I may join in." We observed the lunchtime experience for people. Where people ate in the dining areas it was relaxed and people were considerably supported to move to the dining areas. People were encouraged to be independent throughout the meal and staff were available if people wanted support, for extra food or drinks. We observed one person who had poor hearing and sight being assisted with their meal. The member of staff knelt on the floor beside them, so that they could talk into their ear with the hearing aid. The member of staff described the meal and how the food was positioned on the plate. They asked the person if they would like their meat cut up, and if they could put a plate guard on to stop the food slipping off the plate. For another person their air cushion was fetched from their room, so they could sit on the chair at the dinner table. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. People were heard to be discussing what they were doing that day. One person said, "My knee is a bit stiff. I'll be glad to get down to the gym today." Another person said, "My legs are feeling a bit stronger now."

People were supported by care staff that had the knowledge and skills to carry out their roles and meet individual people's care and support needs. The registered manager told us all new care staff completed an induction before they supported people. This had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide

compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new member of care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. New members of the care staff told us they had recently been on an induction. This had provided them with all the information and support they needed when moving into a new job role.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people using the service, which included moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Health care staff were able to provide training and support in catheter care, stoma care, diabetes, Parkinson's disease and dementia care. Staff had also received training or guidance on providing care and support to people receiving a rehabilitation service. We spoke with staff about the training opportunities on offer. One member of staff told us, "There is training here. I've done all of my mandatory training." Another member of staff told us, "Yes, I've done stoma training and training in Parkinson's Disease. I've also done my NVQ (National Vocational Qualification) Level 5". Nursing staff had been supported and provided with information on courses they could attend to keep their clinical skills updated and current. Staff had been supported to complete a professional qualification, of the 35 care staff employed, 31 care staff had a Diploma in health and Social Care Level 2 or above.

Staff told us that the team worked well together and that communication was good. Staff told us they had received supervision from their manager, they felt well supported and could always go to a senior member of staff for support. They told us they provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. There was a supervision and appraisal plan in place which the senior staff were following to ensure staff had regular supervision and appraisal. Additionally there were regular staff bulletins to keep staff up-to-date and discuss issues within the service. Records confirmed this.

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, nurses or dieticians and when referrals had been made. A consultant geriatrician visited weekly to support people with more complex medical needs. Feedback from the healthcare professionals we spoke with supported this. Care staff told us that they knew the people well and if they found a person was poorly they should report this to the manager. People were supported to maintain good health and received on-going healthcare support.

Is the service caring?

Our findings

People told us people were treated with kindness and compassion in their day-to-day care. They told us they were satisfied with the care and support they received. They were happy and liked the staff. People were seen to be comfortable with staff and frequently engaged in friendly conversation. Comments received by staff in the service this year included, 'It's been a joy to know you and also get such loving care. You will be remembered with affection for many years,' 'All the staff are so kind and helpful even when under pressure' and 'We are so happy that she is here with your lovely team.'

People were involved in making decisions about their care wherever possible. People were listened to and enabled to make choices about their care and treatment. Staff ensured they asked people if they were happy to have any care or support provided. For example, we observed staff supporting people with their exercise programme, and encouraging people to complete these. They were supporting people to improve their skills and reach their goals for more independence. Staff provided care in a kind, compassionate and sensitive way. They answered questions, gave explanations and offered reassurance to people. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. Staff were attentive and listened to people, and there was a close and supportive relationship between them.

We observed care in communal areas throughout the day. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed excellent interactions between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistently high standard. For example, at lunchtime we observed staff interacting with people in the dining room. There was a convivial and inclusive atmosphere; people who required assistance were helped in a discreet and respectful manner.

Care provided was personal and met people's individual needs. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it influenced them today. Care staff demonstrated they were knowledgeable about people's likes and dislikes. Staff spoke positively about the standard of care provided and the approach of the staff.

Feedback from the service's own quality assurance questionnaires from between April and September 2016 detailed 100% of respondents stated 'always' or 'usually' when asked if they were treated with dignity and respect. People told us care staff ensured their privacy and dignity was considered when personal care was provided. We observed signs were hung on the outside of people's doors when personal care was being delivered to ensure people did not just walk in. We asked how people's dignity and privacy were maintained and observed care in communal areas. We spoke with staff, including the service's dignity champion. We

noted staff were respectful and kind to people living at the home. We observed instances of genuine warmth between staff and people. One staff member told us, "We need to make sure people are included and treated with respect. We don't get to know people very well as they don't stay, but we don't treat them like numbers and work with them rather than at them". Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they protected people's dignity and treated them with respect. One member of staff told us when they assisted people with their personal care, "I ask for their consent and give them options." Another member of staff told us they, "Knocked and waited for people to invite us in." We observed staff knocking on people's doors and waiting before entering.

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity.

People had their own bedroom and en-suite facility for comfort and privacy. They had been able to bring in small items from home to make their stay more comfortable, such as small pictures. People had been supported to keep in contact with their family and friends, and told us there was flexible visiting. People were able to use the public phones sited in the service and there was free internet access provided. Senior staff were able to confirm they knew how support people and had information on how to access an advocacy service should people require this service.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Is the service responsive?

Our findings

People told us felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. One person told us, "I have felt involved in my care plan, the staff have very quickly got to know me." People knew that the purpose of their stay at Knoll House was to try and assist them to regain mobility and independence. They were being supported to achieve their goals and move on to other accommodation. One person told us, "(Staff member's name) wanted me to do the stairs today, but I didn't have the confidence, so we just went down into the gym and worked on the smaller steps." Another person told us, "I've been very ill and (Staff member's name) has got me walking, I can use two different Zimmer's (Walking frames)."

At the last inspection on 23 September 2015 we found areas of practice in need of improvement. This was because the information which had been detailed in individual care plans for staff to follow was variable, had not always been fully completed and did not always give clear guidance for care staff to follow. Where care had changed it was not always possible to identify when this had occurred and the rationale for the change. Additionally people told us they would have liked more opportunities to join in social activities. During this inspection, we found improvements had been made and issues identified had been rectified.

The registered manager told us everyone received a comprehensive assessment undertaken by nurse assessors employed by Sussex Community NHS Trust. This identified the care and support people required to ensure their safety, so staff could ensure that people's care needs could be met. Records we looked at confirmed this.

People told us they or their relative had been involved with the care planning and review. One person told us, "My daughter is involved with my care planning." A relative told us, "I was involved in the care planning for my Dad. (Staff member's name) the physio was very lovely, he came and assessed my Dad." Care staff told us that care and support was personalised and confirmed that where possible, people were directly involved in their care planning. The format of the care and support plans was consistently used by the intermediate care services across the provider's services. These were compiled and updated by health and social care staff and contained guidance about the care and support needs of the individual. They included information about the needs of each person for example, 'This is Me' information and what the person's individual goals were, their communication, nutrition, and mobility needs. People had been involved with agreeing to their goals and care and support plan. Goals were important for people to work towards as part of their rehabilitation programme to support them to return home. The care and support plans had been reviewed and people's progress towards their goals monitored and the information used to inform their discharge requirements.

Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift between health and social care staff. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. There was a shift plan in place which described tasks that needed to be undertaken either 'am' or 'pm' and also recorded the staff member allocated to complete each task.

There were opportunities for people to join in social activities during their stay, for example there were organised film shows, board games, art and crafts and cooking sessions. Staff also facilitated one to one activities for example, using the iPad, playing games and arts and crafts. Staff told us at times it could be difficult to provide social activities around the rehabilitation work people were involved in. However, work had been undertaken since the last inspection to improve the frequency of the provision of social activities provided. This had also been a standing item on the staff bulletins to keep all staff informed of the developments of social activities. The deputy manager had the lead for social activities and Thursday afternoons had also been set aside for group activities. Feedback from the service's own quality assurance questionnaires from between April and September 2016 detailed 84% of respondents stated, 'I was able to spend my time/do enough as I wanted, doing things that I value or enjoy.'

People told us they had guidance and regular support from the physiotherapists, and occupational therapists. These specialists had worked with them to improve their mobility prior to return home. They told us of the exercises they were being supported to undertake. One person told us, "The facilities here are outstanding, I get a physio session everyday. I'm treated as an individual." Another person told us, "(Staff member's name) makes me do as much as I can; I have improved with what I can do since I've been here." Twice a week there were multi-disciplinary meetings, where health and social care staff met to discuss people's care and support needs, their progress towards their agreed goals and to identify when people were due to leave and their care and support needs to help them move on to other accommodation. Feedback from staff was that these meetings were informative and worked well. People told us they had the care to be provided under this scheme explained to them. They all spoke well of the care that was provided. They told us they had access to health care professionals, doctors and community nurses through the intermediate care scheme when they needed them. Records we looked at confirmed this.

People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans, and by completing quality assurance questionnaires. Comments received from feedback from the service's own quality assurance questionnaires from between April and September 2016 included, 'I have been happy with my stay,' 'Very pleased with everything and happy with my stay at Knoll House,' 'Knoll House does everything well. I have been very happy here,' 'All the staff are so kind and helpful even when under pressure,' 'Everything,' and 'Lovely having my own room. Great food, good physio, gym. (Staff member's name) was wonderful invaluable and persistent help to get me free of my catheter, thank you. All lovely staff thank you again.'

People told us they felt it was an environment they could raise any concerns and knew who to talk to. One person told us, "If I had a complaint I would speak to the manager or care leader." Another person told us, "I'm sorry I can't complain, it's too good here." We looked at how people's concerns, comments and complaints were encouraged and responded to. People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which was available in people's bedrooms. One relative told us they had raised some concerns and had done this by going to the office. They commented, "I felt listened to." Another person told us, "Everybody has time for you if you have a problem." In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Is the service well-led?

Our findings

People told us they felt the service was well led. One person told us, "I would recommend Knoll House to anyone, it has lived up to everything I wanted and more." Feedback from a health care professional was that the service worked well and was well organised, staff engaged with them and there was a good working relationship. One relative told us, "My mum came in here lying in a bed after two major operations, she's now up and washing and dressing herself and walking down the corridor to lunch on her own." Another relative told us, "(Registered manager) has been fantastic, nothing but kindness, couldn't be better."

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager. There was a team of registered nurses and service support managers. The senior staff promoted an open and inclusive culture by ensuring people, their representatives, and staff were able to comment on the standard of care provided and influence the care provided. Staff members told us they felt the service was well led and that they were well supported at work. They told us the managers were approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "The manager is brilliant. They don't miss a thing. I think some people underestimate them." Another member of staff told us, "I don't think things have been easy for the manager lately as there's so much uncertainty about the future. They've been great though. The best manager I've ever worked with."

Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understanding of the importance of respecting people's privacy and dignity. One member of staff told us, "It's about getting people back on their feet again." Another member of staff told us, "The focus is very much on rehabilitation. It's about returning people to a normal life if they can." Comments received by staff in the service this year included, 'Thank you for your wonderful care when I left Knoll House. It really put me on my feet. When the opportunity arose for someone else to do it, I felt it only fair to let someone else have my place. So I felt I should let someone else benefit from your expertise but I do miss you! You all do a wonderful job. Carry on the good work,' and 'Everyone has been so kind and helpful, helping me recuperate back to my old self (almost there).'

Senior staff carried out a range of internal audits, including care planning, checks that people were receiving the care they needed, progress in life skills towards independence, medication, health and safety and infection control. They were able to show us that following the audits any areas identified for improvement had been collated into an action plan, work completed to address any shortfalls and how and when these had been addressed. The provider's representatives visited and audited the care provided. Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future. The registered manager told us staff meetings were now less frequent and had been replaced by regular staff bulletins with updates for staff on the service. They had found this a more effective way of keeping staff up-to-date with what was happening in the service.

The registered manager had regularly sent statistical information to the provider to keep them up-to-date

with the service delivery. This gave the provider information on staffing, incident and accidents, complaints and the maintenance of the premises. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run. The registered manager told us that where actions had been highlighted these had been included in the annual development plan for the service, and worked on to ensure the necessary improvements. Records we looked at confirmed this. The registered manager was able to attend regular management meetings with other managers of the provider's services. This was an opportunity to discuss changes to be implemented and share practice issues and discuss improvements within the service.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. Policies and procedures were in place for staff to follow, and current guidance had been used to regularly update policies and procedures.