Brighton and Hove City Council

Brighton & Hove City Council - Knoll House

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 23 September and 7 October 2015 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.

Summary of findings

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 days 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 service was going through a significant period of review, where the provider and local stakeholders were looking at the service provision and what was needed and how the service would best be provided in the future.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Senior staff had policies and procedures to follow and demonstrated an awareness of where to get support and guidance when making a DoLS application. Not all the care staff had received training or guidance on DoLS, and were not aware who had a DoLS agreed. This meant there was the possibility of a lack of consistency of the care provided and agreements as part of the DoLS application not being followed. We have identified this as an area of practice that needs improvement

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. We have identified this as an area of practice that needs improvement.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place for the proper and safe management of medicines. However, one medicine awaiting disposal was not being stored in a specific way as was required by law. Guidance on the care plan and medicines administration record (MAR) used to record the administration of medicines for one person were not consistent to ensure a consistent approach when administered. We have identified this as an area of practice that needs improvement.

People's individual care and support needs were assessed before they moved into the service. Care and support provided was personalised and based on the identified needs of each individual. People had a care and support plan and risk assessments in place, which had been reviewed. The detail for staff to follow was variable and did not always give 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 not been consistently recorded. This meant there was a risk that care would not be provided consistently. However, staff told us that communication throughout the service was usually 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. We judged this had not impacted on the care that people had received, but is an area which needs to be improved upon.

People told us they felt safe. They knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. One person told us, "It's a lovely place to be." The service was clean 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.

Summary of findings

Senior staff monitored peoples 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 told us they had felt involved in making decisions about their care and treatment and felt listened to. They were treated with respect and dignity by the staff, and were spoken with and supported in a sensitive, respectful and professional manner. One person told us, "They respect my dignity and encourage my independence." Peoples healthcare needs were monitored and they had access to health care professionals when they needed to. People spoke about the support they had received as part of their rehabilitation. One person told us, "With the help of people here I can get back to what I was." Another person told us,"I am aiming to go home and working with the physiotherapists". One member of staff told us, "The service works well for people who are able to be rehabilitated."

People's nutritional needs had been assessed and had a selection of choices of dishes to select from at each meal. People said the food was good and plentiful. One person told us, "It's very nice food, homely cooking. If I didn't like what I had chosen I could ask for something else." 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 visitors could discuss any issues they may have.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe. People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. However, 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.

Procedures were in place to ensure the safe administration of medicines. However, the storage of one medicine awaiting disposal did not meet current requirements. Guidance on the care plan and medicines administration record (MAR) used to record the administration of medicines for one person were not consistent to ensure a consistent approach when administered

There were sufficient staff numbers to meet people's personal care needs.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff were aware of the deprivation of Liberty Safeguards (DoLS). However, staff were not aware who had a DoLS agreed and in place and the care and support they needed as part of this agreement.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. However, where people needed additional support to ensure they had sufficient food and fluid the records were not consistently completed to fully inform staff people had received adequate to eat and drink. People had access to health care professionals when they needed.

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

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.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive. People had been assessed and their care and support needs identified. Care and support plans were in place, however the detail and guidance in place for staff to follow was variable as had not always been fully completed.

There were limited opportunities for people to participate in recreational activities. 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 23 September and 7 October 2015 and was unannounced.

The inspection team consisted of three inspectors one of whom was a pharmacist inspector. 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 requested the provider to complete a Provider Information Return (PIR) which they completed and returned. 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).From this information, following our inspection, we telephoned a health care and social care professional to ask them about their experiences of the service provided.

We spoke the registered manager, the deputy manager, two registered general nurses (RGN), a physiotherapist, seven care workers, and a cook. We observed the care and support provided in the communal areas, and the mealtime experience for people over lunchtime living on the first floor. We spoke with seven people who were living in the service.

We looked around the service in general including the communal areas, and people's bedrooms. As part of our inspection we looked in detail at the care provided to eight 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 four staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

We last inspected this service on 13 May 2014 when the service was compliant with all the regulations we reviewed.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and were well treated in Knoll House. However, we found areas of practice in need of improvement.

To support people to be independent, risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. People had individual assessments of potential risks to their health and welfare and these or activities they were involved in to help them reach their agreed goals and move onto further accommodation. Individual risk assessments where completed including 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 (pressure sore) an air mattress (inflatable mattress which could protect people from the risk of pressure damage) 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. However, we found that the record of these checks to show that these had been maintained had not been regularly completed. This could have potentially placed people at risk of skin damage or developing pressure sores if the setting was not correct. We discussed this with the registered manager who told us this would be rectified.

People told us they got their medicines in a timely way. One person told us, "They bring you your medicines when they are due. I ask what they are for and they tell me." 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. People were encouraged to 'self-medicate' where possible within a risk management framework.There were regular visits from a pharmacist employed by the Sussex Community NHS Trust. We were shown their intervention records and subsequent actions taken in the service or other partner organisations. We were also shown the most recent audit undertaken by staff at the service and the actions they were intending to take to rectify any concerns.

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. Information to support the administration of medicines was available. However, 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 on as to why their medicines should be taken was not the same on both documents to ensure a consistent approach when administered. We have identified this as an area of practice that needs to be improved upon.

We looked around the building and we 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 a 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, 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 were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and

Is the service safe?

poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

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.

Staff told us how staffing was managed to make sure people were kept safe. 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 peoples care and support needs which helped them check there were adequate staff on duty. Staff told us although at times it could be busy there was adequate staff on duty to meet people's care needs. They told us minimum staffing levels were maintained. Recent staff absence and recruitment difficulties had led to a lack of consistency in the staff Sussex Community NHS Trust providing nursing care in the service. We were told the trust had ensured recruitment drives were being undertaken to try to address this. The provider's bank staff or agency staff was used to cover any care staff absences. Where possible staff were requested who had previously working in the service and had an understanding of how the service was run were requested. They also spoke of good team spirit.

People told us there were enough staff on duty to meet their needs. 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, "When I press my call bell they always come." Another person told us, "When I press my call bell they respond or talk through to me."Another person told us,"Yes they do answer the bell quickly."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.

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. We found records of an application form being completed, an interview and two written references and a criminal records check having been received.

Requires improvement

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,"Food is beautiful. Compliments to the chef. We are spoilt here." However, we found areas of practice in need of improvement.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and gave us examples of how they would follow appropriate procedures in practice. The MCA 2005 is a piece of legislation which provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make specific decisions for themselves. The registered manager had the support of an onsite social work team, who provided guidance and support. They told us that if they had any concerns regarding a person's ability to make a decision they had liaised with the social work team and ensured appropriate capacity assessments were completed. Staff were aware of any decisions made for people who lacked capacity had to be in their best interests. 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 consent to any care or treatment to be provided. We asked care staff what they did if a person did not want the care and support they were due to provide. One member of staff told us, "Give options, explain everything, ask if they want a bath or a shower." People confirmed they were given the choice each day of a bath or a shower. However, 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. This as an area of practice that needs to be improved upon.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). 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. The registered manager told us they were aware how to make an application to deprive someone of their liberty. They talked with us about the three applications which were currently in place. Senior care staff told us they had completed this training and all had a good understanding of what this meant for people to have a DoLS application agreed. However, not all the care staff had received training or guidance, but had an understanding of what a DoLS application was. The registered manager told us care staff were being supported to attend this training. However, where a DoLS had been agreed this had not been documented in the care and support plan. Care staff were not clear who if anybody had a DoLS application agreed, or if there were any actions they had to follow to support people where an application had been agreed. This meant there was the possibility of a lack of consistency of the care provided and agreements as part of the DoLS not being followed. This is an area of practice that needed to be improved upon.

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. We were told that the nursing staff on duty were responsible for overseeing these. However, records were not all accurately maintained to detail what people ate or drunk to fully inform the nursing staff and enable them to assess if people had adequate food and fluid during the day, to maintain their wellbeing. For one person the records detailed they had not had food or fluid since the previous lunchtime. This is an area that needed to be improved upon.

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. One person told us about the fortified juice they had to reinforce their nutrition intake. This was in response to a review of their diet.

The cook told us there was a three weekly 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. For example, whether a low potassium or diabetic diet was required. This showed us that staff were aware of individual's preferences, needs and nutritional requirements. However, not all the care staff demonstrated knowledge of people's individual dietary requirements. We observed in one lounge that there was a lack of knowledge of people individual dietary needs. Two people had to remind care staff of foods which had been identified in their care plan, they were being given that they could not have. This is an area of practice that needed to be improved upon.

Requires improvement

Is the service effective?

People spoke well of the food provided and staff came in advance to ask them what they would like to eat. However, they told us they had to make their choice several days in advance so that when the day came they could not remember what they had chosen. One person told us, "They come around with a menu and I get to choose." Another person told us, "The food is absolutely beautiful here. They come around with a menu. If I did not like what I have chosen, they could make me something else."Another person told us, "Food is lovely especially lunch. Supper can be a bit hit and miss." People told us they had a choice of either eating their meals in their room or in one of the dining rooms.We observed the lunchtime experience for people. It was relaxed and people were considerately supported to move to the dining areas, or could choose to eat in their bedroom. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation.

People were supported by care staff that had the knowledge and skills to carry out their roles and meet individual peoples care and support needs. The registered manager told us all care staff completed an induction before they supported people. This had recently 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 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 training in 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 and guidance on providing care and support to people receiving a rehabilitation service. Nursing staff had been supported and provided with information on courses they could attend to keep their clinical skills updated and current. One member of staff told us their manager, "If there's training I am interested in, she'll put me on it." Staff were being supported to complete a professional qualification, for example one person told us they were working towards a Level 3 Diploma in Health and Social Care and, they told us, "It gives you more knowledge and more confidence."

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 meetings 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, social workers, nurses or dieticians and when referrals had been made. A consultant geriatrician visited weekly to support people with more complex medical needs. One member of staff told us, "If I am worried about someone's mental health needs I email the mental health team and they will come and assess. I feel supported by the mental health nurse." 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 ongoing healthcare support. One person told us, "They are organising the dentist for a loose tooth."

Good

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. One person told us, "I've been here about a month. Staff are very nice here.The staff always wave when they walk past my room." Another person told us, "I tell them because they deserve to know they are very good." We observed people and staff in the communal areas. People were seen to be comfortable with staff and frequently engaged in friendly conversation.

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. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listened to people, and there was a close and supportive relationship between them.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met peoples 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, dislikes. Staff spoke positively about the standard of care provided and the approach of the staff. One member of staff told us of the care that was provided, "It's nice to see people improving and going home."

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. One person told us, "Staff are very good, always knock before they coming in." Another person told us, "They respect my privacy and dignity. They do everything well. They are all nice." There were three privacy dignity champions who worked in the service. We spoke with one who told us they regularly attended the support group meetings for dignity champions held in the city. They brought back information for the staff team. They talked with staff using scenarios to promote and inform their understanding of dignity. There had recently been a dignity week held. One member of staff told us,"That as part of the week a coffee afternoon had been held and a talk on dignity arranged. Staff encouraged people to attend and asked them what worked well and what could be improved in the service. We also spoke with people in their own rooms to get their thoughts as well. All the information was collated and from that feedback staff were working on a new welcome pack for people when they arrived in the service, and a structure chart identifying who was who in the service being drawn up for people to reference."

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 how protected people's dignity and treated them with respect. One care 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, "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 ensuite 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 internet access provided. People had not required support when making decisions

Good

Is the service caring?

about their care from an advocacy service. 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. One member of staff told us, "Handovers are done with the door shut, and they never discussed people's care needs in the corridors".

Requires improvement

Is the service responsive?

Our findings

People told us they were asked for their views about the service. They said they 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. They were being supported to achieve their goals and move on to other accommodation. However, we found areas of practice in need of improvement.

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 in the service. If they felt they did not have enough information to make a decision they requested further information. Records we looked at confirmed this. One member of staff told us, "This is a good multidisciplinary team to meet people needs."

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 across the intermediate care services across the provider's services. These were compiled and inputted into 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 persons individual goals were, their communication, nutrition, and mobility needs. There were instructions for care staff on how to provide support tailored and specific to the needs of each person. These had been reviewed. One member of staff told us, "Care plans are informative. They are much better and nursing staff are putting on a lot more notes."

However, the detail which had been completed 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 the when this had occurred and the rational for the change. For one person according to the handover sheet they were a diet controlled diabetic. This was not detailed on their care and support plan and a diabetic care plan was not put in place. The lack of guidance for care staff to follow had the potential for a lack of a consistent approach in the care and support provided. Not all the care plans had people's goals recorded, or a record that people had been involved and agreed to their goals and care and support plan to help them achieve these. Goals were important for people to work towards as part of their rehabilitation programme to support them to return home. However, staff told us that communication throughout the service was usually good and included comprehensive handovers at the beginning of each shift between health and social care staff and regular staff meetings which they used to update themselves on the care and support to be provided. 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. Catering staff were aware where people were on special diets. Feedback form the health and social care professionals was that guidance they had given as to the care provided had been actioned and followed through. We judged this had not impacted on the care that people had received, but is an area which needed to be improved upon. We discussed this with the registered manager as shortfalls in the completion of peoples care and support needs had been highlighted in the providers own quality assurance audit completed in February 2015. They acknowledged this was an area they were already working on with staff and regularly auditing to monitor improvements.

Peoples social care needs had not been consistently identified what they liked to do and this information had been completed on their care and support plans. There were some opportunities for people to join in social activities during their stay, for example there were organised film shows, playing board games and cooking sessions. However, there was lack of regular activities being offered for people to join in. We discussed this with the registered manager as this had also been highlighted in the providers own quality assurance audit in February 2015 as an area in need of development. We were told that a member of the care team had been identified and now had the lead to try to develop the range and frequency of activities provided for people to participate in. They also told us that there had also been a lack of people wanting to join in activities which had been provided. However, social activities are important to enable people to have social

Is the service responsive?

engagement and promote their wellbeing. With the continual change around of people with varying needs in the service the provision of meaningful activities is an area in need of improvement.

Twice a week there were multi-disciplinary meetings, where health and social care staff met to discuss peoples 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. One person told us, "I feel they look after you here. It's a place to transfer people from hospital to help them get well. There are some lovely people here." Another person told us,"I did request Knoll House. I heard it was good." 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 saw confirmed this. 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 returning home. They told us of the exercises they were being supported to undertake. Comments received included,"Everyday I have exercises. I go to the gym downstairs occasionally and the team are very nice. I have made lots of progress." Another person told us, "I practice walking and do exercises every day. With the help of people here, I can get back to what I was. I saw the physio assistant today, and we went into the kitchen and practiced making a cup of coffee." Another person told us, "They encourage us to try to exercise and walk. "One member of staff told us,"Some people are able to mobilise, but not able to shower independently. We encourage them to get into the shower, and empower them to wash independently. People with more complex needs, we encourage them to do what they can do, giving them a choice."

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. There was information in the service to inform people of how their ideas had been used to make improvements in the service. For example some of the telephones for people to use had been repositioned for easier accessibility. The front door was now easier for people to access and exit independently. Touch lamps and radios had been purchased for people's use.

People told us they felt it was an environment they could raise any concerns. 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. No one we spoke with had raised any concerns. People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. Where any concerns had been raised these had been recorded and responded to appropriately. 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.

Good

Is the service well-led?

Our findings

People told us they felt the service was well led. A member of staff told us the service was, “Run like a tight ship.” They also told us “I love the team.” Another member of staff told us, “The staff are very good. Management are very approachable.” Feedback from the health and social care professionals was that the service worked well and was well organised, staff engaged with them and there was a good working relationship.

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 senior care staff. The senior staff promoted an open and inclusive culture by ensuring people, their representations, 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 staff member told us, “The manager is the best one in 30 years. She’s on the floor. She’s excellent.”Another staff member told us, “The management team are all very approachable.” Another member of staff told us, “If I was not happy with something I would go to (the registered manager.)

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 understood the importance of respecting people’s privacy and dignity. One member of staff told us,”We provide good quality care. The main aim is to prevent hospital admission, and try to get people home where possible. I think it works very well.”

Staff meetings were held throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred. We saw that the feedback following the recent dignity week had been shared with staff. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service.

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 providers visited and audited the care provided. We looked at the last record of their visit which detailed they had looked at recording and 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. For example, falls was the highest proportion of incidents, and a themed audit on slips, trips and falls was carried out. The main reason for this was to try and establish if there are any common patterns or themes across the service with regards this type of incident and if there was anything staff can learn from investigating further, and therefore any best practise that could be shared.

The registered manager had regularly sent statistical information to the provider to keep them up-to-date with the service delivery. We looked at the last report which 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. However, there was not a policy and procedure on people’s responsibility under the Duty of Candour. We discussed this with the registered manager during the

Good

Is the service well-led?

inspection. Following this the registered manager sought advice and looked up information about this during the day. We were told this information would be used to ensure guidance was in place for all staff to follow.