Brain Injury Rehabilitation Trust

Kent House

Inspection report

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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 08 and 10 June 2016. It was an unannounced visit to the service.

We previously inspected the service on 15 April 2014. The service was meeting the requirements of the regulations at that time.

Kent House is a care home for adults who have an acquired brain injury, some of whom may live with a physical disability. It is registered to provide accommodation for 22 people. At the time of our inspection 20 people lived at Kent House.

The service had a registered manager in post. 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 home is located in a residential setting; people who lived at the home were familiar with the local area and neighbours.

People were protected from avoidable harm. Risk assessments were comprehensive and gave good detail on how staff should support people to live and full and active life.

People received their medicines when needed; we observed good practice by staff when they administered medicines.

People were protected from abuse as staff had received training on how to recognise it. Staff knew what to do in the event of a concern being raised and would not hesitate to use a confidential whistle-blower helpline.

Incidents and accidents were recorded. Onward referrals were made when the need was identified. For instance, when someone was identified at high risk of falling, they were referred to the specialist healthcare professionals at the service which helped to maintain balance and muscle strength through exercises.

People had access to healthcare and good systems were in place to monitor people's health and appointments were made in a timely manner. A therapy assistant supported staff; they told us "We offer a unique programme to maintain health."

The home worked within the principles of the Mental Capacity Act 2005, and where required, appropriate referrals were made to the local authority to authorise a deprivation of liberty.

People had access to a wide range of activities both within the home and the local community. External

events like a charity gardening scheme and a singing group were attended by people.

People were supported by staff, who provided a person centred service. Care plans reflected individual likes and dislikes, and gave a good description on how staff needed to support people. Staff had developed good working relationship with people.

People knew who to talk with if they had any concerns. Management were visible and approachable.

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.

There were enough staff to meet people's needs.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures for staff to follow in the event of any abuse happening.

People were supported by staff with the right skills and attributes because robust recruitment procedures were used by the service.

Is the service effective?

Good

The service was effective.

People received safe and effective care because staff were appropriately supported through a structured induction, supervision and training.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005.

People received the support they needed to attend healthcare appointments and keep healthy and well.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with respect and their privacy and dignity were upheld and promoted. People and their families were consulted with and included in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People were able to identify someone they could speak with if they had any concerns. There were procedures for making compliments and complaints about the service.

People's preferences and wishes were supported by staff and through care planning.

The service responded appropriately if people's needs changed, to help ensure they remained independent.

Is the service well-led?

Good

The service was well-led.

People and relatives had confidence in the management. Management were visible and accessible.

People were supported by management that continually monitored the quality of service provided. The registered manager worked with external agencies to drive improvement in the service.

Records were well maintained and stored safely.

Kent 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 08 and 10 June 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. The inspection was carried out by one inspector.

The provider did not complete a Provider Information Return (PIR), as we did not ask them to. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with the seven people living at Kent House who were receiving care and support, one relative; the registered manager, deputy manager and 10 staff including senior care staff, care staff and therapy staff.

We reviewed six staff files and four care plans within the service and cross referenced practice against the provider's own policies and procedures.

We looked at some of the required records, these included, six staff files, four care plans in detail four records relating to medicines. We cross-referenced practice against the provider's own policies and procedures.

We also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who lived in Kent House.

Good

Is the service safe?

Our findings

People told us they felt safe at Kent House. Comments included, "I feel safe, I do, but if I was worried I would speak to my keyworker." Another person told us, "There are plenty of staff working here."

People were protected from avoidable harm. Risk assessments were completed for a wide range of topics, including falls and manual handling. Risk assessments were comprehensive. They gave prompts for staff to identify changes in people's behaviour which indicated that risks were escalating and how to lessen them. The risks to people's well-being were reviewed regularly by a member of staff. The service had support from a multi-disciplinary team including psychology and occupational therapy. Where people were able to understand the risk assessment process, they were encouraged to sign the risk assessment.

Prior to the inspection we spoke with the local care home pharmacist. Their role was to support care homes achieve safe practice in medicines management. The pharmacist had worked with the service and had made a number of recommendations. We saw the service was working through an action plan to improve medicine practice and had made some of the recommended changes.

People's prescribed medicines were managed safely. Staff who provided support with medicines had received training. Medicines were stored securely. Where additional storage and recording for medicine was required, this was provided. We checked stock levels of medicine that required additional safeguards. Records were accurate and well maintained. We observed good hygiene techniques prior to and whilst medicines were administered. We observed that records were accurate and updated as required. We observed a medicine administration round. Staff did not rush this task. The service had a medicines policy which included details of homely remedies. The policy stated a record of stock should be maintained and a weekly check of stock was required to ensure all were in date. We checked the homely remedy medicines; we found they were stored safely and securely. However, we found no record of stock control. We asked the deputy manager about this. They confirmed no records were completed for stock control; however, they stated stock was checked regularly. The deputy manager advised this would be recorded in the future.

People were protected from abuse. The service had a safeguarding procedure in place. Staff received training on how to safeguard people. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. One member of staff told us "If someone was withdrawn or was acting strange, it would alert me that something may be wrong." Contact details for the local safeguarding team were displayed around the home. Staff we spoke with were aware of what to do in the event of a concern being raised. One staff member said, "I would not hesitate to contact the manager if I had a concern." All the staff we spoke with told us they would call the whistleblowing telephone number if they felt issues were not being dealt with appropriately. The service had made referrals to the local authority when suspected abuse occurred.

The service operated robust recruitment processes. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Where initial references lacked detail, the registered manager sought further details

or additional references. Where information regarding previous criminal convictions were disclosed. A thorough risk assessment was undertaken and was signed off at director level. This meant the provider ensured staff had the right skills and attributes to work with adults at risk.

We observed staffing levels over the course of two days. We saw where people had been given funding for one to one support, this was provided. We had no concerns over the staffing levels observed. However, some staff we spoke with told us "We could do with one more staff member, especially when there is a lot going on" and "It can be quite difficult working here." However, all the staff we spoke with told us the registered manager and deputy manager helped out during busy times. We observed both the registered manager and deputy manager were visible throughout the inspection.

Environmental risks were identified and managed. Equipment used regularly by the service was maintained and repairs conducted when needed. Hoists in place were serviced; water and gas safety checks were undertaken and certificates were in date. Incidents and accidents were recorded and where required onwards referrals were made. For instance, one person, who had a number of falls, was referred to the specialist healthcare professionals at the service who held an exercise programme to help prevent further falls.

The service had procedures in place to deal with emergencies. Personal emergency evacuation plans were in place which detailed what support was required in the event of an emergency. Fire procedures were displayed in many areas within the home. There was a person identified to undertake regular fire tests and fire drills. Records seen confirmed these happened.

Good

Is the service effective?

Our findings

People received effective care which supported them to live their lives in the way they chose to. People had access to healthcare and there were good systems in place to monitor people's health and wellbeing. When concerns were raised about changes in a person's health, these were responded to quickly and efficiently. For instance, we observed that a person had complained about painful teeth. We saw the concern was recorded in daily notes and an appointment was made with the dentist. The appointment was written in the diary and a letter was prepared confirming the appointment. The service had developed a form which people took with them to a medical appointment. It recorded the issue, what had been discussed together with the outcome of the appointment. This meant the service was able to support people achieve good health and well-being. One relative told us "If there are any concerns, X (manager) rings me straight away. Once I took (relative) out and when we got back staff were concerned how (relative) looked. They (staff) checked (relative) over and took some observations."

People were supported by staff who were aware of their roles and responsibilities. Staff received training the provider deemed mandatory. This included epilepsy, safeguarding and fire safety. The service used a mix of face to face training and e-learning. The registered manager monitored staff attendance at training and where staff were required to attend training, reminders were sent to the member of staff. Staff told us they received an induction to the service. This included learning about brain injury and the provider's core values. Staff did not work alone until they had worked alongside more experienced care staff. Staff received support from a line manager; this included one to one meetings and an annual review of their performance. The provider had a range of policies which supported the registered manager deal with staffing issues. This included management of long term sickness and poor performance.

People were consulted on what they would like to eat. The menu and food choices were discussed at resident meetings. The kitchen staff went round each morning to ask people what they would like to eat that day from the menu. We observed where people did not want to eat at the main lunchtime, food was offered at a time that suited them. Information on healthy eating was displayed in the dining area. People who required a pureed diet were provided this. However, on day one of the inspection we observed all the individual components of the meal had been blended together. This meant the food was not able to be identified. We spoke with the registered manager about this. An alternative was quickly offered. The registered manager advised us they had an agency chef covering the kitchen. The registered manager told us they would ensure guidance was available for anyone who covered the kitchen to ensure this did not happen again.

On day two of the inspection we observed a drink being given to a person who required thickened fluids. Prior to the person drinking it, we asked the registered manager to check the drink, they confirmed it had not been thickened and went to check other people's drinks. The registered manager advised us that all staff would be reminded about how people should have their drinks provided.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
One person received their medicines covertly on days they did not want to take it. We saw this had been authorised and a best interest discussion had taken place. The registered manager was aware of their responsibility to make applications to the local authority. We saw where changes in someone condition occurred, reference was made to the DoLS authorisation and if it required to be updated a new application was made.

The service operated a handover meeting from shift to shift; this provided an opportunity for staff to share important information regarding care and treatment for people. The handover was undertaken in a closed office, which meant that confidentiality was maintained. We saw important information was also recorded on a handover sheet. The service had a large white board on display in the office; this was updated daily with important information. The shift leader allocated work at the beginning of the shift. We observed staff referred to this when they commenced their shift. Where staff commenced work after the main shift, the shift leader updated them on what had happened prior to their arrival.

The service worked closely with a local advocacy team. Advocates are independent of the service and provide support to people to express their views. On day one of our inspection we observed an advocate was visiting a person who lived at the home.

Good

Is the service caring?

Our findings

People told us they were happy at Kent House. Comments included "I feel a lot better now," "I live a good life here." A relative told us "I am very, very happy; I could not be more pleased." Another relative told us "I know a handful of staff really well, as they have been there for a long time."

We observed people were relaxed in the company of staff. One person told us "The staff are good, they are marvellous." Some people had one to one support from staff. It was clear from our observations that staff understood people they were supporting. For instance staff spoke with people about their hobbies and family.

Staff were able to demonstrate they supported people in the way they wanted to. For instance, one staff member, who had been supporting a person on one to one, told us the person wanted to go to the shops. They therefore arranged to take them into town to go shopping. One person told us they were going out to a club with their one to one support.

Staff were knowledgeable about people, their life history and likes and dislikes. We observed staff talking to people about a film which was on the television. They were taking about other films the actor had been in.

People were involved in decisions about their care. Information was made available to people about certain events going on. For instance, the service had arranged to celebrate the Queen's birthday. Posters were displayed about this. Before residents' meetings occurred, a poster was displayed showing the date and time they were to be held. People were encouraged to discuss how they were supported and decisions were recorded in minutes which were distributed to all who lived in the home. This meant that people who did not attend were also informed of discussions held.

The service operated a keyworker system. A keyworker was a member of staff who had been identified to take the lead in knowing a person. The keyworker's name was displayed in people's room. Staff met with people on a regular basis. The service called this a 'primary carer meeting'; a record of this was made. We saw that topics discussed included, 'what have you enjoyed' and 'do you want any changes to your daily planner'.

Staff gave people choices. We observed where people required assistance by staff to move around the home, staff asked them where they would like to sit. We also observed staff offered choices of drinks and activities.

Staff demonstrated kindness and compassion. The registered manager shared with us information about a person they had supported until their death. The person had lived at the home for some time. They had been very unwell several times. The registered manager told us how the service had arranged their funeral as they had no family members. Staff who no longer worked in the service were contacted to share their memories of the person. The registered manager shared with us the eulogy they had written. It clearly demonstrated a genuine kindness and fondness towards the person. It also demonstrated how touched the

staff had been by the presence of the person and their time at Kent House.

We observed rooms were personalised. People were free to take items of importance into the home. We saw that people were encouraged to choose what colour they wished their room to be painted.

Staff we spoke with described the service as a "Big family." Comments from staff included "I never have a day I don't want to come to work," "It's not like coming to work," and "I think the team are genuinely caring and committed to providing person centred care." Staff were able to demonstrate how they promoted dignity. One staff member told us "(named person) tends to come out of their room in their nightie; I always offer them a dressing gown."

People's religious beliefs were recorded and people were supported to go to church when they wanted to.

Good

Is the service responsive?

Our findings

People received person-centred care and had access to a wide range of activities. The home had a stable resident population. The last person, who moved into Kent House, did so three years ago. Some people had lived at the home in excess of 15 years. Prior to moving into the home, there was a robust pre-admission assessment process. The registered manager used the information gathered in the assessment, to decide if they could meet the support the person required. This was also discussed with the wider multi-disciplinary team, which included psychology and physiotherapy.

The deputy manager had been nominated and won a runner up prize at the local authority's dignity awards. The nomination was made by the Quality in Care team, for work completed on care planning. Care plans were well written. Care plans were linked to risk assessments, which provided continuity of information for staff to follow. One person had a care plan which detailed what equipment was needed to best support them. Staff understood this and we observed the equipment stated was used. Another person's care plan stated they needed to practice standing balance. We saw this was undertaken on day two of our inspection.

The service had a one page profile for each person who lived at Kent House. The document gave an overview of each person It included, 'What is important to me', 'Things I enjoy', 'About me' and 'How best to support me'. This was a quick reference guide which gave staff information about the person at a glance.

The service had support from a therapy assistant; they supported the physiotherapist, occupational therapist and psychology staff. The work undertaken by the therapy assistant supported what care plans stated. Information about people's progress in therapy sessions was recorded. We saw the intervention from the therapy team was person-centred. We spoke with the therapy assistant and they told us they had made referrals to Remap, a charity which produced bespoke equipment to support people's independence. An adaptation had been made to a person's wheelchair as a result.

People were supported to engage in activities of their choice. Some people attended a local charity which provided gardening opportunities. One person attended a session, 'singing for the brain', which was arranged by the Alzheimer's society. The service hosted a college course. We observed a session in action. People were encouraged to engage in activities which promoted independence. The college facilitator told us "We are trying to adapt the course to people's needs." For instance, one person who was a keen knitter before their accident was interested in this as an activity.

Activities were discussed at the residents' meetings. We observed that one person had requested to visit a museum and another person had asked to go abroad. Other suggestions made by people at the residents' meeting were creative writing and going out to shows.

One person, who lived at Kent House, had taken responsibility for a library service. They provided a weekly library service. We saw them going around and asking people if they wanted anything to read. Books were provided by the main town library.

The service had a complaints procedure. No formal complaints had been received in the service; however, we saw low level concerns were responded to quickly by the registered manager. Feedback was sought from people at monthly 'primary worker' meetings and through annual reviews. One relative told us "We have an annual review and they (service) really go to town, to ensure everyone who needs to be there is present."

Good

Is the service well-led?

Our findings

People were aware of who the manager and deputy manager were. We observed that people would seek them out to ask them questions. On relative told us "(manager) has been brilliant, the whole pathway has been good, she has not only supported (relative) but the whole family." Staff told us management operated "A real open door policy" and "Service users know who she is." Another staff member told us "(manager) is very approachable." There was a clear management structure, which staff recognised and understood. Staff were aware of the provider's aims of objectives. Staff we spoke were enthusiastic to provide an environment which people could call home. Management met with staff on a regular basis to discuss the service, staff felt empowered to raise concerns about the service and had a confidential whistleblowing telephone number. Staff told us they had confidence to use this they felt it was required.

The registered manager had signed up to the 'social care commitment.' This is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks. Each commitment focused on the minimum standards required when working in care. The commitment is aimed to increase public confidence in the care sector and raise workforce quality in adult social care. The registered manager told us they hoped every care worker would also sign up. This demonstrated they were committed to continuous improvement.

The registered manager had access to a wide range of policies to support them to manage the service. We reviewed a number of these policies. We found that they had not always been updated when the provider said they would be. We spoke with the registered manager about this. They told us this had been communicated to the quality team and was being addressed. The service was located in a residential area, the registered manager told us that neighbours to Kent House were familiar with residents. One person who lived at the home supported a neighbour by walking their dog. The registered manager felt residents of the home were part of the local community. The neighbours had been invited to the planned garden part to celebrate the Queen's birthday.

The service had quality assurance process in place, these included regular audits, which looked at medicine, nutrition and care plans to name a few. These were conducted by staff who worked in the home. In addition, the provider visited the service to undertake quality assurance reviews. The registered manager was responsible for sending information to the provider on a monthly basis. This included falls and safeguarding concerns. This was an opportunity for the provider to look at themes and trends to help prevent future incidents.

The registered manager engaged with the local authority and clinical commissioning group. We saw that previous recommendations had been adopted by the service. For instance, a recommendation had been made that photographs of people who lived at the home have a date for when they were taken, this was in place.