Brain Injury Rehabilitation Trust

Fen 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

Fen House is a residential rehabilitation service. It provides accommodation, personal care and treatment of disease, disorder and injury for up to 25 people who have experienced an acquired brain injury. It is not registered to provide nursing care.

There were 22 people living at the home at the time of this visit. There are internal and external communal areas, including lounge areas, separate dining rooms, an activities room, a gym, two communal bathrooms and court yards for people and their visitors to use. The home is made up of two floors which can be accessed by stairs or a lift. All bedrooms are on the ground floor have en-suite facilities including a toilet, basin and shower. There are two smaller kitchens for people to use to support and maintain their independence. There is also a self-contained flat for a person to live in with the support of staff prior to them moving back into the community.

During this inspection there was some work being undertaken on the building. This was being managed to make sure that there was little or no impact on people living in the home. This unannounced inspection took place on 24 February 2016.

There was a registered manager in place during this inspection. 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 Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Where people had been assessed as lacking capacity to make day-to-day decisions, decisions were made in their best interest. Applications had been made to the local authorising agencies to lawfully restrict people's liberty where appropriate. Staff demonstrated to us that they respected people's choices about how they wished to be supported.

Records were in place for staff to monitor people's assessed risks, support and care needs. Plans were put in place to minimise people's identified risks and to assist people to live as safe a life as possible whilst supporting their rehabilitation and independence.

Arrangements were in place to ensure that people were assisted with their prescribed medicines safely. People's medicines were managed and stored appropriately. People's nutritional and hydration needs were met.

When needed, people were able to access a range of internal and external health care professionals. People were supported to maintain their health and well-being. Staff supported people with their interests and hobbies and to maintain their links with the local community to promote social inclusion. People's friends

and families were encouraged to visit the home and staff made them feel welcome.

People were supported by staff in a compassionate and respectful manner. People's care and support plans gave guidance to staff on any individual assistance a person required. Records included how people wished to be supported, what was important to them and their rehabilitation goals.

Staff understood their responsibility to report any poor care practice or suspicions of harm. There were pre-employment safety checks in place to ensure that all new staff were deemed suitable and safe to work with the people they supported. There was a sufficient number of staff to provide people with safe support and care.

Staff were trained to provide care and support which met people's individual needs. The standard of staff members' work performance was reviewed during supervisions, spot supervisions, competency checks and appraisals. This was to ensure that staff were confident and competent to provide people's support and care.

The registered manager sought feedback about the quality of the home provided from people, and their relatives as they were able to raise any suggestions or concerns that they had with the registered manager and staff and they felt listened to.

Staff meetings took place and staff were encouraged to raise any concerns or suggestions that they may have had. Quality monitoring processes to identify areas of improvement required within the home were in place and formally documented any action required.

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 supported with their medicines as prescribed. Medicines were stored safely.

Systems were in place to support people to be cared for in a safe way. Staff were aware of their responsibility to report any concerns about poor care and suspicions of harm.

People's care and support needs were met by a sufficient number of staff. Safety checks were in place to ensure that new staff were deemed suitable to look after the people they supported.

Is the service effective?

Good

The service was effective.

Clinical staff were aware of the key requirements of the MCA and DoLS to ensure that people were not having their freedom restricted in an unlawful manner.

People's health, nutritional and hydration needs were met.

Staff were trained to support people to meet their needs.

Staff were trained and supported to provide effective care and support to people.

Is the service caring?

Good

The service was caring.

Staff were compassionate and respectful in the way that they assisted and engaged with people.

Staff respected people's right to privacy and dignity.

Staff encouraged people to make their own choices about things that were important to them and encouraged people to maintain

their independence.

Is the service responsive?

Good

The service was responsive.

Staff supported people to maintain their hobbies, interests and their links with the local community to promote social inclusion.

People's care and support needs were planned and appraised to make sure they met their current needs.

People knew how to raise a complaint should they wish to do so. There was a system in place to receive and manage people's compliments, suggestions or complaints.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

Audits were undertaken as part of the on-going quality monitoring process. Any improvements required were documented and were actioned or being worked upon.

People and their relatives were able to feedback on the quality of the home provided and feel listened to.

Fen 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.

This inspection took place on 24 February 2016, and was unannounced. The inspection was completed by one inspector and a specialist advisor. A specialist advisor is a person who has experience of working with people with an acquired brain injury.

Before our inspection we looked at all the information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about. We also received feedback on the home from a representative of the Cambridge and Peterborough clinical commissioning group and a complex case manager/deputy team leader.

We spoke with four people who lived in the home. We spoke with the registered manager, a consultant in psychology and rehabilitation, assistant manager and a chef. We also spoke with a team leader, two rehabilitation support workers, a shift leader/rehabilitation support worker, and an activities co-ordinator. Throughout this inspection we observed how the staff interacted with people who lived in the home and who had limited communication skills. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records, the systems for monitoring staff training and two staff recruitment files. We looked at other documentation such as quality monitoring, relatives and people's feedback questionnaires, accidents and incidents, maintenance and safety records. We saw records of compliments and complaints, and medication administration records.

Good

Is the service safe?

Our findings

People said that they felt safe in the home. This was because of the care and support that was provided and how staff treated them. One person told us that they, "Felt safe with the little bit of support from staff." Another person said, "I feel very safe, nobody bothers me. I have my own flat and I speak to anyone I want. I can lock my door if I want to, but I never had to do this because I felt unsafe. I normally leave my door open with the knowledge that nobody will walk in."

Staff said that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of abuse and report any suspicions of harm or poor care practice. Staff told us what action they would take in protecting people and reporting such incidents. We saw information on how to report suspicions of poor harm on communal notice boards within the home. This was for people, visitors to the home and staff to refer to if needed. This demonstrated to us that there were protocols in place to reduce people's risk of harm.

People had individual risk assessments undertaken in relation to identified support and health care needs. These included but were not limited to a pre-admission risk assessment being completed prior to admission into the home. Individual risks identified included; people being at risk during manual handling, whilst in bed, at night time, in the event of a fire, and any mental health risks. Each risk identified had a management plan in place with a checklist to review and make sure that these documents were up to date. These risk assessments and records provided prompts and guidance for staff on how to support and monitor people safely.

Our observations showed that people were supported by staff to take their prescribed medicines safely, in a patient and unhurried manner. People told us that they had no concerns about the management of their prescribed medicines. We were told that all staff who administered medicines had received appropriate training. One staff member said that in order to administer medicines, "I had to do training followed by a competency test and supervision." Records confirmed this. We saw that people's prescribed medicines were audited both internally and by the associated pharmacy to ensure of their accuracy. Actions were taken for any improvements required. We noted that there were clear instructions for staff in respect of how and when medicines were to be administered safely, including those to be given 'when required.' This meant that there were systems in place to manage people's prescribed medicines safely.

Staff said and records confirmed that pre-employment safety checks were carried out prior to them starting work at the home and providing care. A staff member said that they, "First attended an interview followed by a police check, then I had a two week induction, this was followed by training. I then had a period of shadowing staff." Checks included references from previous employment. A criminal record check that had been undertaken with the disclosure and barring service, proof of current address, photographic identification, and any gaps in employment history had been explained. These checks were in place to make sure that staff were of a good character and that they were suitable to work with people living at the home.

During our inspection we saw that there were sufficient staff on duty to meet people's assessed needs.

People's current dependency requirements were assessed and this determined how much care and support from staff would be needed. We saw that the staff skills mix was consistent with the rehabilitation programmes in place for the people living at the home. Our observations showed that people's requests for assistance were responded to quickly and that staff whilst they were busy, people were not hurried.

People had individual personal evacuation plans in place in case of an emergency. This showed us that there were plans in place to assist people to be evacuated safely in the event of a foreseeable emergency for example a fire.

We looked at the inspection checks and certificates for safety assessments on the home's utility systems and fire safety checks. Where there were improvements required such as the maintenance of some fire doors that required updating, there were action plans to monitor these. This showed us that the management made checks to ensure people were, as far as practicable, safely cared for in a place that was safe to live, visit or work.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provided 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. We spoke with the registered manager and a consultant in psychology and rehabilitation about the MCA and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. Records we looked at confirmed that people's capacity to make day-to-day decisions had been assessed and documented with best interest meetings held. Where people had been assessed as lacking the mental capacity to make day-to-day decisions, decisions were made in their best interest and these were documented. Applications had been made to the local authorising agencies to lawfully restrict people of their liberty where appropriate. Where people's capacity had improved we saw evidence that applications were appropriately withdrawn. On the day of our visit we looked at a random sample of applications. We saw that applications that had been authorised were in date and conditions of these were followed.

Staff demonstrated to us that they respected people's choice about how they wished to be assisted. Records showed that only some staff had received training in MCA and DoLS. The registered manager told us that this was because MCA and DoLS was the responsibility of the clinical team within the home. On speaking to non-clinical staff we noted that their knowledge about MCA 2005 and DoLS was variable. The registered manager had already identified this as an area requiring improvement and we noted that training for non-clinical staff members had been arranged.

People told us that they were happy with the food served in the home. They said that the quality of the food was very good and a good choice to choose from. During our SOFI we saw that one person kept complimenting staff on the lunch. They said, "This is very nice, thank you." People also confirmed to us that food was available to them outside of the set meal times. The chef talked us through any special dietary needs and how this would be catered for; this included food prepared for people with a specific health care condition or people who required their food to be in a softened form due to identified risks of poor swallowing. To ensure that people maintained their independence and to prepare people when they left the home, there were two small kitchens. These were used by people with support from staff to help prepare snacks and prepare and cook meals. One person said that they baked cakes and shared them with other people living in the home. Another person told us how they had been accompanied by staff to go food shopping in a local supermarket and then they helped prepare and cook the food they had bought. This, they said, had made them feel like they were making good progress with their recovery.

People were provided with a selection of hot and cold drinks throughout the day. Our observations during the meal time showed that people could choose where they wanted to eat their meals. We saw that some people ate their lunch in the dining area, but some people had chosen to have their meals in their room. Where people needed some support we saw that staff encouraged people to eat at their own pace. This assisted the person to eat their meal with limited support while maintaining their independence.

Staff said that when they first joined the team they had a two week induction period which included mandatory training and shadowing a more experienced member of staff and supervision. This was until they were deemed confident and competent to deliver safe and effective care and support. Staff told us about the training they had completed to make sure that they had the skills to provide the individual support and care people needed. This was confirmed by the record of staff training undertaken to date. Training included, but was not limited to; equality and diversity; fire safety; MCA; DoLS; safeguarding adults; infection control; first aid; basic brain injury; nutrition and well-being; medication; and moving and handling. One staff member said that to develop their skills they had been supported to undertake additional training. They told us, "I also received training from the physiotherapist, occupational therapist, speech and language therapist, psychologist and qualified staff. I feel that the place prepares you to do the job, this is why I enjoy it." Another staff member told us, "As a result of my personal development plan, I now do two days as a rehab [rehabilitation] assistant and three days as assistant psychologist. This will hopefully help me in becoming a [named role]." A third staff member said, "I find it very satisfying learning on the job. I have been a [named role] for some time and somebody is shadowing me in order to become a [named role]." This demonstrated to us that staff were supported to develop and maintain their knowledge and skills.

Staff members told us they enjoyed their work and were well supported. One staff member said that it was their wish, "To work here until I retire." Staff said they attended staff meetings and received formal supervision, competency checks and an annual appraisal of their work. This demonstrated to us that staff were supported within their roles.

The home employed health care professionals such as psychologists, physiotherapists, occupational therapists, and speech and language therapists to be involved in people's care and well-being and support people's rehabilitation. One person confirmed to us that, "I had input from the psychologist, physiotherapist, speech and language therapist, dieticians, occupational therapist and nurse and rehabilitation staff."

Good

Is the service caring?

Our findings

People had very positive comments about the service provided. One person said about the staff, "They are brilliant, I can't fault them." Another person told us it was, "People talk to you all of the time, always reassuring you. Before coming here, I did not want to come. They gave me information that helped me make my mind [up]. They persuaded me in a friendly and caring manner to come for rehabilitation. Here I am today walking with a stick from being in bed and all with a smile." A third person said, "I did not think that walking could take so long. What is incredible is that at first it took up to three staff to get me to stand up and they had the patience to do it. I would have given up a long time ago if I was in their shoes. They do it day in and day out for so many people. You can only have admiration for their hard work."

Staff took time to support people when needed. We saw staff supporting people and that this was all done at the person's preferred pace and without rushing them.

People's care records showed that staff had taken time to gather people's personal and social histories and their preferences. These were then taken into consideration when planning all aspects of their care. One person told us, "When I came here they asked me for a lot of details, but they also provided me with a lot of information." Care records had been written in a way that promoted people's privacy, dignity and independence. We also saw that care records were written in people's own words and supported by coloured pictures. One person said, "It is easy when you have the pictures to show you each step that you have to do." Care reviews took place to make sure that people's care and support plans were up-to-date and met people's current needs. We saw documented evidence that people were involved in these reviews of their care. Another person told us, "I was assessed as having capacity and was fully involved with my care." This demonstrated to us that staff got to know and develop an understanding about the person they were supporting through rehabilitation.

Staff talked us through how they made sure people's privacy and dignity was respected and promoted when they assisted them with their personal care. One person said, "Staff respect [the privacy of] people's rooms, they knock and wait. They wait for the 'come in'." This was confirmed by our observations throughout the visit. People's rooms had been decorated with personal belongings to make people feel more at home. We saw that staff were polite and addressed people in a respectful manner and by the name they preferred. We noted that staff asked people if they needed support with their personal care in a dignified way. People were cleanly dressed and appropriately for the temperature within the home. This demonstrated to us that staff treated the people they were assisting in a respectful and dignified manner.

Staff talked us through how they encouraged people to make their own choices to promote and maintain people's autonomy. For example, what time they would like to get up, what people would like to eat, where they would like to take their meals or what they would like to wear. People said that they could ask for help from staff when needed and talked us through how they were encouraged by staff to make their own choices. This demonstrated to us that people were supported by staff to be involved in making their own decisions and that staff respected these choices.

People's friends and family were encouraged to visit the home by the registered manager and staff. People were also supported by staff to spend time back at home and in the community with their family as part of their rehabilitation. One person talked us through how important it was to them and their well-being to spend time at weekends back home with their family.

Advocacy services information was available for people should they wish to use this information. Advocates are people who are independent of the home and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

People had positive opinions on the activities on offer at the home, trips out to promote social inclusion and links with the community and individual rehabilitation goals. One person told us about their up and coming trip out to a local nature reserve with much excitement as this was one of their interests. People had recorded rehabilitation goals for a period of at least twelve weeks. We saw that these were reviewed weekly. Another person said, "I knew what my goals were from week to week and the people that will be working with me to achieve my goals." This rehabilitation programme was designed to help with people's independence and develop new skills and interests. Rehabilitation goals included, using the gym, laundry tasks and shopping for, preparing and cooking meals. Activities included memory groups, art and crafts including the painting of ceramics as seen during this inspection. One person said that they liked the art room as it was an opportunity to socialise with other people as well as an opportunity to do activities that they had not done in years.

Care and support plan were developed by staff in conjunction with the person, and/or their family. These provided guidance and prompt to staff on the care and support the person needed. The individual support that people received from staff was in response to their assessed needs. One person said how their brain injury had left them almost totally dependent on others for all of their activities of daily living. They said, "I was unsteady on my feet and could not walk. I had difficulty swallowing and lost my appetite. I was incontinent. I needed help with my personal care. I was depressed on account of my situation and I had difficulty sleeping. The future looked bleak. I thought that going to the rehabilitation centre was like going to a [derogatory term used] and rejected the idea. When staff came to assess me they persuaded me that rehabilitation could make me more independent…... I was fully involved with my care." They went on to tell us, "When I arrived at the unit there was a wheelchair waiting for me. They [staff] took a lot of information from me like personal details and preferences. They gave me a lot of information about the care I would be receiving and the disciplines that would be involved……. I can now understand the different impact the staff had on me becoming more independent."

Support included assistance with their prescribed medication, personal care assistance, attending health care appointments, rehabilitation goals, and meal time support. Reviews were carried out regularly to ensure that people's current care and support needs were recorded as information for the staff that supported them.

We saw that the home had received compliments from relatives and people who had previously lived at the home as feedback on the quality of the service provided. People told us that that they knew how to raise a suggestion or complaint should they need to do so and they would be confident to that a suggestion or complaint would be listened to. One person told us, "I am very happy with the help that I have received since coming here, I have no complaints." Staff said that they knew the process for reporting concerns or complaints. Records showed that the complaints received had been responded to in a timely manner and resolved to the complainant's satisfaction.

Good

Is the service well-led?

Our findings

There was a registered manager in place and they were supported by an assistant manager, head of care, clinical staff, rehabilitation support workers, and non-care staff. People told us that they knew who to speak with and spoke positively about the staff.

Quality monitoring systems were in place to monitor the quality of the service provided within the home. These checks included, but were not limited to; people's care plans, the environment, medication, hygiene and nutrition. Audits were also carried out on staff files to ensure that accurate records were kept. We also noted that the divisional manager also visited the home and a report from this visit included any areas of improvement. We saw that any improvements needed were either completed or being worked on and that these were documented in an action plan.

Accidents and incidents were also looked at as part of the quality monitoring of the service. Statistics from these incidents were reviewed to identify any 'key trends' or 'common themes' and formed part of the registered manager's quality monitoring protocol to improve the service. This meant that there was a robust system in place to monitor the on-going quality of the service provided.

The registered manager had an understanding of their role and responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred while a service was being provided. Records we looked at showed that notifications had been submitted to the CQC in a timely manner.

Staff told us that they were free to make suggestions, raise concerns, and that the registered manager was supportive to them. One staff member said that the reason they all enjoyed their work was that they had a common focus of, "Caring for people." Another staff member told us that senior staff were very supportive, "They work alongside you… most things work in harmony." Records we looked and staff confirmed that staff meetings happened regularly. These meetings were also used as opportunities to update staff on the service. Staff were also given the opportunity to be nominated for awards as part of the disabilities trust [the registered providers scheme to value staff members]. We saw that staff at Fen House had won the team award category in 2015. This meant that staff were supported within their roles and were given recognition of their work.

The registered manager sought feedback about the quality of the service provided from people who lived at the home and their relatives by asking them to complete questionnaires. Questionnaires returned showed that the feedback was positive.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This showed us that they understood their roles and responsibilities to the people who used the service.