Bristol City Council

Bristol North Rehabilitation Care Services

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 was an unannounced inspection carried out on 9 August 2016. When Bristol North Rehabilitation Care Services was last inspected in November 2014 we found that not all staff had received appropriate training and the provider had failed to send a legal notification to the Commission as required. During this inspection in August 2016, we found that the required improvements had been made.

Bristol North Rehabilitation Care Services provides a rehabilitation service for a maximum of 20 people aged over 18. The service supports people with rehabilitation and ensures people can care for themselves independently before returning to their own homes following a life event such as a hospital admission or an illness. There was a multi-disciplinary team that supported people which included rehabilitation workers, physiotherapists, occupational therapists, pharmacists and nurses. At the time of the inspection there were five people using the service.

A registered manager was in post at the time of 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 and associated Regulations about how the service is run.

During our inspection in November 2014, we found that staff had not always received appropriate training to carry out their roles safely and effectively. This meant that people could be at risk of receiving unsafe or inappropriate care. In addition to this, the provider had not sent a legal notification as required. The provider wrote to us in January 2015 and told us how they would achieve compliance with the standard. During this inspection, we found the provider had taken the action they had planned.

People at the service felt safe and we saw there were sufficient staff of duty to support people safely. People's needs and risks had been assessed, and an identified risk had been reduced through guidance and monitoring. People received the required level of support they required with their medicines whilst aiming to achieve independence before discharge from the service. Recruitment procedures were safe and incidents and accidents were monitored and reviewed when needed.

People told us they received care and support when they needed it. Since our last inspection staff had received regular training. There was a supervision and appraisal process to support staff development. We saw staff implementing the Mental Capacity Act 2005 in their work by empowering people with choices. The overall feedback on food within the service was positive and where required people were supported with their nutritional needs. Malnutrition risks were assessed and people were weighed regularly. People were supported to use healthcare services and the service liaised with other healthcare professionals as required.

People spoke highly of the staff and we observed good relationships between people and staff. People's visitors were welcomed at the service and we received positive feedback from the visitors we spoke with about the quality of care provided. People received information about the service on admission and we

observed people's privacy and dignity was respected. The service had received numerous compliments from people and their relatives.

People told us that staff were responsive to their needs and we made observations to support this. People had allocated keyworkers to support them during their stay at the service and people's needs and preferences were discussed with them on admission to help staff provide personalised care. There was a system that allowed the provider to obtain feedback from people following their discharge from the service and the provider had a complaints procedure people could use.

The registered manager was visible and supported staff. Staff spoke positively about their employment and told us they were supported by the registered manager with training, supervision and appraisal. There were systems to communicate with staff and annual surveys to monitor employee welfare. There were governance systems to monitor risks to people's health. The registered manager had submitted notifications as required and the requested Provider Information Return (PIR) was returned within the specified time frame.

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's risks were assessed and identified risks were managed

People at the service felt safe

Staff knew how to respond to actual or suspected abuse

There were sufficient staff on duty and recruitment was safe

People received the support they required with their medicines

Is the service effective?

Good

The service was effective

People said they received effective care from staff

Staff had received regular training to meet people's needs

Staff received supervision and appraisal

People commented positively on the food at the service

The service communicated with relevant healthcare professionals

Is the service caring?

Good

The service was caring

People were treated in a caring and compassionate way

People received important information about the service

Staff understood people well and were aware of their needs

People's privacy and dignity was respected

People's relatives were welcomed

Is the service responsive?

Good

The service was responsive

People said they received personalised care

We observed staff responding to people's needs

People had a nominated keyworker who provided direct support

There were systems to collect feedback to improve the service

A complaints process was available for people to use

Is the service well-led?

Good

The service was well led

Staff spoke positively about their employment

There were systems that monitored the welfare of staff

There were governance systems to monitor risks to people

The management communicated key messages to staff

The Provider Information Return was returned as required

Bristol North Rehabilitation Care Services

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 was 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 was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

On the day of the inspection we spoke with all five people currently using the service, however two of those people did not wish to speak with us in depth. In addition to this, we spoke with two people's relatives. We also spoke with registered manager and two other members of staff. We observed how people were supported and looked at three people's care and support records.

We looked at records relating to the management of the service such as staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Good

Is the service safe?

Our findings

People and their relatives said they felt safe and commented positively on the staff that supported them. One person told us, "I called in the middle of the night soon after I came here. I was uncomfortable and couldn't sleep. A member of staff came and made me comfortable. She also made me a cup of hot milk which helped me go back to sleep." Another person said, "Oh yes, I feel very safe here."

Identified risks to people were reduced through assessments and risk management guidance. Within people's records we found risk assessments for people that were completed on admission to the service. Assessments of people's risks of skin damage were completed, and if a required guidance for staff on how to reduce this risk was produced. For example, we saw within one person's record that the assessment had identified staff should complete a full check of a person's skin twice a week to see if they were at risk of developing skin damage. Supporting records showed that these checks had been completed. A falls risk assessment was completed, and where required, guidance for staff showed if the person needed to be supported by staff to mobilise or transfer. The provider also used a nationally recognised tool to monitor people's nutritional risks to identify if a person was at risk of malnutrition or obesity.

During our inspection in November 2014, we made a recommendation that the service followed nationally published guidance by Diabetes UK. The recommendation we made related to the section of the Diabetes UK guidance that recommended all people in a care home environment had an individualised care plan tailored to their needs in relation to their diabetes. This recommendation was made as there was no risk management guidance that showed what action staff should take should people become unwell. During this inspection we spoke with the registered manager who stated that although previous care plans for people had been written with diabetes guidance, there was no person currently at the service who was diabetic. This meant we could not evidence if the provider had implemented the recommendation we made, but this will be checked at future reviews.

People received the required level of support they required with their medicines. The service actively promoted people's independence with their medicines to be sure they would be able to safely self-medicate when they were discharged. People had their medicines stored in their rooms and the level of support people received from staff varied. People did not raise any concerns in relation to receiving their medicines. People had their own individual medicines records within their rooms. People's care plans contained records that showed medicine balances were regularly checked and monitored to ensure stock levels were sufficient. People's individual Medicine Administration Records (MAR) were completed accurately. There was an assessment tool in place to establish if people could safely manage their own medicines. A record of when people became independent with their medicines was completed which people had signed to demonstrate their agreement. Staff competency in medicine administration was monitored and recorded by senior management.

The provider had appropriate arrangements to identify and respond to the risk of abuse. Staff told us they had received training in safeguarding and said they would feel confident when reporting concerns. There was a policy in place for safeguarding identifying the different types of abuse and how to report concerns.

Staff told us they would report concerns internally to the registered manager or other senior staff members, but also knew they could contact external agencies such as the Commission of local safeguarding team. Staff said they understood the concept of whistleblowing and the provider had a whistleblowing policy. This provided staff with guidance on how they could raise concerns about the workplace confidentially internally and externally. We did highlight to the registered manager that although staff knew they could contact the Commission to whistleblow, within the current policy there was no details of how staff could contact the Commission. This was also highlighted at our previous inspection in November 2014.

The provider had ensured there were sufficient numbers of staff to support people safely. The service was currently only admitting a small number of people and staffing levels had been altered to reflect this. There were three full time managers currently employed at the service in addition to care and support staff. No concerns were raised by people or staff around the current staffing levels and we made observations that people got support from staff when they needed. Staffing levels were determined by the use of a dependency assessment tool which we reviewed. This ensured that should people's level of need increase or decrease, or if a person was admitted with a higher level of need, the staffing levels would be increased to reflect this. The registered manager told us that when admissions increased staffing numbers would be altered to reflect this.

We spoke with the registered manager about staff recruitment. They explained that no new members of care and support staff had been recruited by the provider for a significant period of time and that the most recently employed staff had been recruited internally from within Bristol City Council. A new member of domestic staff had recently been employed at the service. From reviewing this file we saw that an initial application form, together with the staff member's previous employment history and employment or character references had been obtained. An enhanced Disclosure and Barring Service (DBS) check that ensured the applicant was not barred from working with certain groups such as vulnerable adults had also been completed.

There were systems for recording incidents and accidents to help ensure people's safety. The registered manager told us there had not been a serious injury at the service resulting from a fall or accident for a period of time. We reviewed the incident log that showed when an incident had occurred it had been reviewed by senior management. Following this review we saw that guidance on reducing the chance of the incident happening again was recorded, along with other action taken. For example, we saw that after a minor fall one person was checked by a nurse and immediately referred to the on-site Occupational Therapist (OT) for an assessment. In addition to this, staff guidance showed the person should be checked more frequently. Another record showed that after a minor stumble, the person was advised to request staff support by using the call bell and that a handling assessment was completed by a physiotherapist.

Equipment used within the service was maintained to ensure it was safe to use. We saw that mobility equipment was serviced such as slings, hoists and stand aid equipment. Bathroom and bathing equipment was also serviced together with any specialist beds. A maintenance book we reviewed showed that boiler maintenance was completed and servicing checks were completed on the fire alarm, emergency lighting and security system. There were also additional systems that ensured that taps within people's rooms were checked and a record of water temperatures was maintained. We saw that where required, moving and handling equipment such as slings had been condemned when deemed unsafe and the registered manager said that it had been highlighted to the provider that new equipment was required.

Good

Is the service effective?

Our findings

At our inspection of Bristol North Rehabilitation Care Services in November 2014, we found that staff had not always received appropriate training to carry out their roles safely and effectively. This meant that people could be at risk of receiving unsafe or inappropriate care as staff had not received training aligned with current guidance or best practice. The provider wrote to us in January 2015 and told us how they would achieve compliance with the standard. During this inspection, we found the provider had taken the action they had planned.

We reviewed the training record supplied by the registered manager. This showed that since our inspection staff training had significantly increased. Staff we spoke with told us the amount of training they received had increased. For example, since our last inspection staff had completed training in food hygiene, basic life support, medication and safeguarding. During a review of the training record it showed that some staff still required training in moving and handling. We spoke with the registered manager about this who confirmed that training for all the staff that required updated training had been booked. This training was being delivered in September 2016 by an accredited member of the provider's training staff.

Additional training had been received to enable staff to meet the needs of the people who may be admitted for the service. For example, at our last inspection the training record showed that eight of the 39 listed staff members had previously received training in diabetes. It was also noted that these eight had completed this training in 2007. This placed some people at risk as the provider had not ensured staff had the required knowledge and skills to support people's specific health needs. The training record now showed that all staff (except one who was not available) had received training in diabetes. In addition to this, some staff had received training in skin care and mental health awareness. Other staff had received specialist physiotherapist and occupational therapist training in movement, anatomy and exercise.

People and their relatives said they received effective care and that their needs were met. We received positive feedback from people and people said they had been receiving their rehabilitation requirements as per their assessed needs. One person said, "I'll be going home very soon. I couldn't have been discharged straight from hospital. I was weak and it would have been too much for my husband. I've done my exercises and now I can go." Another person commented, "I was in so much pain when I came here. I'm so much better now. I like to be independent so I've tried really hard. Everyone has been very helpful."

Staff received regular performance supervision and appraisal. The provider had recently implemented an electronic supervision and appraisal process for some staff in addition to those who had written records. The new electronic system allowed staff to set long term and short term objectives, for example any training the staff member requested or courses they wished to attend. This would then be progressed through the year. In addition to this, a discussion was held relating to the staff members performance and a performance rating given. Staff we spoke with told us the system worked well.

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. During our inspection, we observed staff following the principles of this, by encouraging people to make decisions by offering people choices. People were offered the chance to go outside with staff into the garden, but their decision was respected when they declined. Other choices included clothing, meal choices and what activities people wished to do.

At the time of our inspection, there was no person living at the service subject to a Deprivation of Liberty Safeguard (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. 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 Mental Capacity Act 2005 (MCA). 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. We spoke with the registered manager who told us they understood when a DoLS application may be needed, however there was no person currently in the service who needed a DoLS.

People gave positive feedback about the food in the service and nutritional risks were managed. We spoke with people about the quality of food provided and the feedback we received was overall positive and people. Upon admission to the service, people had a risk assessment completed in relation to their risk of malnutrition using a screening tool. Following the completion of this tool it was recorded how frequently the person required their weight to be recorded. From reviewing the supporting records, we saw that people had been weighed in line with their assessed needs. Where people were prescribed liquid supplements to support them with weight maintenance they received them. Staff we spoke with were knowledgeable about people's nutritional needs.

People were supported to use healthcare services. People were temporarily registered with a local GP practice for the duration of their stay at the service to ensure they had prompt access to a GP. The registered manager told us the only time this would not happen was if the person's regular GP wished for the person to remain registered with them. A weekly round by a GP from the local practice was completed to ensure people's health needs were monitored but visits could be completed sooner if required. Upon their discharge from the service, the person was registered back with their own GP. We reviewed people's discharge documentation that showed the service communicated effectively with the relevant GPs to ensure care continuity was maintained. As part of their rehabilitation, people had access to other healthcare professionals such as occupational therapists and physiotherapists in order to achieve the goals of their admission to the service.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the staff at the service. All said the staff were kind and caring and we made observations that supported this. One person said, "The staff always knock before they enter and are always extremely helpful." Another person told us, "I've really made progress since coming in. They've made a real difference."

People could be visited by their friends and relatives. This meant that people admitted to the service were not isolated from their family or from people who were important to them. We saw that the service operated a 'visiting hours' period during the day which was primarily to ensure that people's visitors did not arrive during times of rehabilitation or physiotherapy. Although there were specified hours, these were flexible and this was evident on the day of our inspection. During the inspection we observed that people's relatives and friends could have tea and coffee to drink.

On admission to the service people were given important information. People were given a 'service user guide' that contained information about the service. For example, the guide contained information on the services statement of purpose, the key personalities within the service and the organisational structure. There was information on the facilities available, meal times, when religious services were being held and how to make a compliment or complaint. This ensured that key information was communicated to people that allowed them to understand the service they were in and who they could contact should they require assistance.

People's privacy and dignity was respected. We asked people if they felt they were treated with dignity by the staff at the service and we made observations to support this. All of the feedback we received from people was positive and all felt their privacy and dignity was maintained. We made observations that supported this. For example, throughout the inspection we observed that staff would knock on people's doors prior to entering. In addition, we saw that where people were in a communal area and the service staff wished to speak with them about their care, people were offered the chance to discuss this in private. When people were receiving personal care or specialist support, we saw that people's doors were closed to afford them privacy whilst this was being completed.

We reviewed the compliment cards sent to the service that showed very positive feedback and was consistent with people's views that we obtained during the inspection. The compliment cards had been received from both people who had used the service and their relatives. We reviewed some of the recent compliments received in 2016 and recorded some extracts. One card from a person's relative read, 'Thank you for all of the wonderful help that your team of helpers gave to my husband.' One from somebody who received care said, 'Many thanks to the members of the reablement team who have helped me during a difficult time. Everyone was so kind.' A further card read, 'I wanted to write and thank you for the loving care displayed and much encouragement given throughout my recovery.'

People were involved in their care and treatment. People had a 'Goal Setting' meeting with their keyworker shortly after arrival. This recorded what the person wished to achieve prior to being discharged. Within

people's records was a rehabilitation plan that covered the set goals. It recorded the person's personal goal, the plan on how to achieve it and how confident the person was that they could achieve it. It gave targets of how the person would know they had achieved their goal and when a review was needed. It was noted that although the record had space for a signature, people had not signed the rehabilitation plans we reviewed.

There were good relationships between staff and people using the service. We made observations that demonstrated staff knew the people they cared for and supported well. People were addressed by staff in their preferred name and communication was polite and friendly. Staff took an active interest in people's welfare and daily activities, for example staff knew when people's relatives were arriving and when they had previously been in. During our conversations with staff they were clear on people's care and support needs. For example why they were at the service, what their goals were and how these were to be achieved prior to the person's discharge.

We made observations of staff supporting people in a friendly, caring manner during our inspection. For example, when staff were supported people to walk around the service we could hear people being offered gentle encouragement and praise. Staff were observed encouraging people's independence which would aid their rehabilitation prior to discharge. For example, one person was being supported by a staff member to transfer into a chair in the lounge. This transfer was done slowly and at the pace of the person the staff member supported. The staff member explained what was happening in a 'step by step' process whist encouraging the person to be independent with the transfer in the safest way possible.

Good

Is the service responsive?

Our findings

People and their relatives said that staff were responsive to their needs and we made observations that supported this. People told us they felt involved in their care and treatment and felt listened to by staff. One person said, "We work on steps as there are lots of steps at home. Just single steps up and down between rooms but I don't want to fall again. I can confidently use steps now." One person's relative said, "I don't think they get enough credit for how fantastic they are here."

We made observations of how the service was responsive to people's needs. For example, during the inspection, and with the knowledge and consent of the person, we were present when a discussion between a person and members of the occupational therapy team was completed. The discussion related to the person's discharge from the service and what they wanted support to achieve. The person was asked what type of things they wished to progress at home, for example climbing the stairs. It was explained to the person that temporary equipment was in their home to support them during progression and how this would help. The person was reminded of the importance of remembering to take their medication.

The staff asked the person if they wished to be referred to the rehabilitation team, and the person was informed what this team could support them with and the timeframes this may happen in. The use of different mobility equipment was also discussed. Throughout this conversation, the staff ensured the person understood their options and choices, and continually invited comment from the person to ensure they understood the options available. This demonstrated people's care were personalised to them, and that they had a say and involvement in the progression of their care. It also showed the service was responsive to the views and opinions of the people it supported.

People were provided with a keyworker to help support with delivering personalised care. People we spoke with understood the keyworker system and we saw that people's named keyworker was recorded within their rooms. The purpose of the keyworker was to ensure people's individual requirements were met. For example, the keyworker was involved in the initial 'goal setting' meeting and discussing the projected discharge date. In addition the keyworker would ensure appointments for people were booked and arrange things such as transport and home visits. Staff we spoke with told us the keyworker system worked well and helped meet people's needs and requirements. Staff we spoke with told us that people were sometimes allocated two keyworkers to account for shift work and absence.

The service had an admissions procedure that encompassed a 'welcome meeting' to ensure people's individual preferences and needs were identified. For example, shortly after admission people would be informed of the fire drills and a personal evacuation plan completed. Staff would check that any mobility equipment the person used was in a serviceable condition. People were advised of the safe facility to use to store money and their dietary needs were discussed. People's preferences in relation to wishing to have either a bath or a shower were discussed and if they had any cultural or religious needs that needed to be met during their time at the service. This showed that although people were only at the service for a short period, personalised information was recorded. This supported staff to deliver care in line with people's preferences.

There were feedback systems that allowed the provider to seek people's views on the service received. We spoke with the registered manager who told us that on discharge people were given a questionnaire about their care. It requested people comment on different aspects of their care. This information could then be used to make changes to the service if needed. We reviewed the period from 1 February 2016 to 31 August 2016. The service had received nine questionnaires back. The results from the survey overall were positive, with all respondents saying they would be either 'extremely likely' or 'likely' to recommend the service to others. All felt they were listened to by staff at the service and said their care and treatment was explained. Everyone said they were welcomed to the service, as were their visitors. All said they were treated with respect and all said they were aware of what they were aiming to achieve at the service.

The service did not run formal social activities for people during their rehabilitation. People did take part in their own rehabilitation exercise with staff and other healthcare professionals during the day as part of their programme. People had access to the communal lounge and kitchen areas of the service. Reading materials were available and people had access to a television in the communal areas of the service and within their rooms if they wanted privacy. There were also crosswords and puzzles that people could access if required. On the day of our inspection people were supported by staff to go into the gardens of the service with staff or their relatives and the weather was nice. People told us this had happened frequently recently due to the better weather.

People we spoke with did not raise any complaints or concerns during our conversations with them. There was a complaints procedure and people were shown this on arrival within their welcome pack on how to use the procedure. The complaints information showed how to raise a complaint with the service but also how to escalate the complaint with the ombudsman should the complainant not feel the matter has been resolved to their satisfaction. The service had not received any complaints since our last comprehensive inspection.

Good

Is the service well-led?

Our findings

At our inspection of Bristol North Rehabilitation Care Services in November 2014, we found the provider had failed to send a statutory notification to the Commission as required. The provider wrote to us in January 2015 and told us how they would achieve compliance with the standard. During this inspection, we found the provider had taken the action they had planned.

We discussed statutory notifications with the registered manager. The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been received when required. In addition to this, we requested a Provider Information Return (PIR) which was completed by the registered manager and the PIR was returned within the specified time frame.

People and their relatives did not raise any concerns about the management and leadership of the service. People said that communication was good and people appeared to understand why their stay at the service was necessary and were very pleased that this provision existed. Most knew what they were aiming towards and felt well supported. They understood the short term nature of the service, and that their time would be spent primarily improving mobility and independent living skills in preparation for their return home. A person's relative said, "We are well informed with regards to our Mum's progress and are involved in decision making."

Staff spoke positively of their employment and of the registered manager. We also made observations of staff supporting each other that showed a good level of teamwork. One member of staff we spoke with when asked about their job satisfaction and the registered manager told us, "It's fantastic - I enjoy my role." They told us the registered manager was, "Very supportive" and spoke positively of the changes at the service since our last inspection and the appointment of the registered manager. The registered manager was described by a staff member as, "Very service user orientated." We were also told that supervision was completed regularly and that communication was good.

There were systems that monitored staff welfare. The provider had a system that allowed staff to feedback if they felt they were under excessive pressure or stress at work. An annual document was sent to staff to establish their views on matters such as the demands of their role, the support they had from their management and peers, their relationships with staff at the service and if any other significant life events may affect their performance. The survey for 2016 was currently being received by the centre manager. They told us that when all of the documents were returned by staff they would be reviewed and an action plan would be created to identify any areas of concern raised.

There were governance systems to monitor the risks relating to the health, safety and welfare of people. We saw that regular audits and submissions were made in relation to the service. For example, one audit was for the 'NHS Safety Thermometer' which is a tool used for monitoring and analysing data to identify care standards. This audit reviewed the current number of people (if any) who had a pressure sore, if anybody currently had a urinary tract infection or was at risk of blood clots. This information was collated and sent to

data analysts at Bristol Community Health. An additional pressure care audit was completed in relation to people's skin damage and pressure ulcers. This showed what people (if any) had a pressure ulcer, if it was present on admission or acquired in the service and what treatment the person received and the healing progression.

The management communicated with staff about the service. The registered manager told us that staff meetings were held about every three months. We saw from the meeting minutes from June 2016 that matters discussed included medicines, people's safety, shift handovers, current vacancies, training and care plans. The minutes from the meeting in April 2016 showed other matters such as healthcare professional referrals and the results of any recent inspections by different regulatory departments were discussed. This showed that key messages were communicated to staff where required.