Brain Injury Rehabilitation Trust

Brain Injury Rehabilitation Trust - Spindlebury

Inspection report

18 Spindlebury Padbrook
Cullompton
Devon
EX15 1SY

Tel: 0188433530
Website: www.thedtgroup.org

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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 announced inspection took place on 8 January 2018. On 15 January 2018 we spoke with members of staff by telephone who were not available at the site visit. We gave the provider 48 hours' notice as this is a small service where people live independently, and we needed to be sure they would be available to speak with us. At our last inspection in November 2015 the service was rated Good. At this inspection we found the service remained Good.

Spindlebury is registered to provide care and support for up to two people. One person was living at the service at the time of the inspection. The service provides care, accommodation and rehabilitation support for people with an acquired brain injury. The service operates in partnership with The Woodmill, an acute rehabilitation service, which forms part of the nationwide rehabilitation support services provided by The Brain Injury Rehabilitation Trust (BIRT).

Spindlebury is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Why the service is rated …

A registered manager was in place but not available on the day of the inspection. The registered manager is also registered as the manager of two other small community based residential services and The Woodmill, a local acute rehabilitation service. They divide their time between the services. 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 provider employed a multidisciplinary team, which consisted of a clinical psychologist; speech and language therapist; occupational therapists and physiotherapists. People using this service were supported by the multidisciplinary team.

People were protected against the risk of abuse and harm. Staff had a clear understanding of safeguarding and how to protect people from abuse and neglect. People's medicines were safely managed. However we have made a recommendation that the service follows the National Institute for Health and Care Excellence (NICE) Guideline, Managing Medicines in Care Homes Published 14 March 2014. This was to help the service to ensure they maintained good practice in relation to medicines management. Risks associated with people's support needs were identified and well managed.

There were sufficient staff available to meet people's needs. People were supported by caring and compassionate staff that had the skills and knowledge to meet the diverse needs of the people using the

service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service support this practice. People were supported to maintain good health. They had access to healthcare services and received on going rehabilitation and healthcare support.

Care was well planned and reviewed with the person, to ensure it continued to meet their needs. People had access to a variety of activities and local community amenities.

Quality monitoring systems, and methods of seeking feedback from people were in place to ensure the service continued to be safe and deliver good quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

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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 announced inspection took place on 8 January 2018. On 15 January 2018 we spoke with members of the staff team by telephone who were not available at the site visit.

The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spent time speaking with one person receiving a service and the member of staff on duty. We also spoke with the interim assistant manager, divisional manager and clinical psychologist.

We reviewed all of the care records relating to one person; three staff personnel files, staff training records and a selection of policies, procedures and records relating to the management of the service. We sought feedback from three health and social care professionals to obtain their views of the service provided to people. We received feedback from one professional.

Good

Is the service safe?

Our findings

People remained safe at the service. One person said they felt safe as they knew staff well and there was always someone available to help them. They added, "We've got lovely staff. We don't have any strange (unfamiliar) staff here. I know them all." A visiting professional said, "They (staff) do a good job. They handle difficult situations well."

People were protected against the risk of abuse. Staff had a clear understanding of safeguarding and how to protect people from abuse and neglect. They had received training about safeguarding, including how to recognise and report abuse. Staff were aware of organisations they could contact outside of the service, for example the local authority safeguarding team or the Care Quality Commission (CQC). All were confident that any concerns reported would be fully investigated and action would be taken to protect people. Where concerns had been raised the registered manager had notified the relevant authorities and taken action to make sure people were safe.

There were sufficient staff on duty to ensure people received safe care. Staffing levels were decided following an assessment of people's individual support needs and adjusted when necessary. For example when one person required support at night, a waking member of staff was on duty. The provider used regular agency staff due to staff vacancies. During the inspection an agency staff member was on duty. They had worked at the service for several weeks and knew people well. The interim assistant manager confirmed recruitment for additional staff was underway. The staff rota showed staffing levels were consistent to meet people's needs and preferences.

Risks to people's health and wellbeing were identified and managed safely. For example where people were at risk of falls, an occupational therapist had completed the care plan and risk assessment, which included guidance about equipment and measures to take to reduce the risk. Where a person displayed behaviours that could be challenging to them and others there were clear instructions for staff. This included the possible cause of the person's anxiety and what distraction techniques they should use to help reduce anxiety. Information explained why people with an acquired brain injury may become anxious or confused. It was clear from discussion with staff that they understood individual's behaviour and how to support them. We saw staff engaging with one person who became upset. Their approach was caring and they followed the guidance in the care plan and risk assessment.

Accidents and incidents were recorded consistently and monitored to show when and where accidents happened. Following an accident or incident the multidisciplinary team discussed the event and care plans and risk assessments were reviewed to ensure risk could be mitigated to reduce future occurrence.

People received their medicines safely and as prescribed and only staff trained in the safe management of medicines administered medicines. The medication administration records (MAR) showed people received their medicines as prescribed. The arrangements for storing people's medicines were safe. There was clear guidance and protocols in place for the use of 'when required' medicines. There was one hand written MAR which had not been signed by two staff to ensure accuracy and accountability. There was also one medicine

which did not have a legible label. This was discussed with the deputy manager and divisional manager who assured us this would be replaced immediately with clear and legible instructions.
We recommend the service follows the National Institute for Health and Care Excellence (NICE) Guideline, Managing Medicines in Care Homes Published 14 March 2014 which would help the service to ensure they maintained accurate medicine records.

Recruitment practices were safe. New employees had been subject to pre-employment checks such as a Disclosure and Barring Service (DBS) check and appropriate references. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Employment histories were recorded along with any gaps in employment.

The premises were adequately maintained and provided a homely space for people. The provider had environmental risk assessments in place to minimise risks to the people who used the service. Regular audits were completed, including infection control and health and safety. A comprehensive annual health and safety audit was undertaken by the provider's health and safety lead. The most recent audit identified some areas for improvement, for example securing a wardrobe and replacing some pieces of equipment. Appropriate timescales for completion had been agreed.

Equipment was serviced in accordance with manufacturer's instructions and there were systems for reporting any maintenance issues. Fire safety equipment had been serviced regularly. However there were some gaps in the fire safety records in relation to checking emergency lighting. The divisional manager explained that these gaps occurred when people were on home leave and the service was therefore empty. They said staff would be reminded to complete all checks as required. Personal Emergency Evacuation Plans (PEEP) were in place for each person to guide staff or emergency staff such as the fire service, about the support people would need to leave the building in an emergency.

The control and prevention of infection was managed well. The service was clean and free from unpleasant odours. Staff had received training in relation to infection control. Cleaning schedules were in place and staff were provided with appropriate personal protective equipment (PPE).

Good

Is the service effective?

Our findings

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's mental capacity had been assessed by the multidisciplinary team led by a clinical psychologist. Applications for DoLS had been made to the local authority as required. Where a person lacked the capacity to make a complex decisions, for example about their placement or health interventions, best interest meetings were held with the appropriate people, including the person themselves. Staff involved people in their care. Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Staff had received training to help them understand the requirements of the MCA and of the implications of DoLS.

People's care needs had been assessed to identify the care and support they required. Assessments included information about their physical and mental health and social care needs and preferences. This enabled the service to plan for and meet their needs. A multidisciplinary team (consisting of a clinical psychologist; speech and language therapist; occupational therapists and physiotherapists) worked with the staff to ensure people's changing needs were identified and addressed. For example, where one person was at risk of falls. The use of equipment had been reviewed to ensure it was of benefit. Staff were supported by the multidisciplinary team to ensure they had the understanding; skills and competencies to meet people's needs in line with up to date standards and best practice relating to acquired brain injury rehabilitation.

Staff had the training, knowledge and skills to meet people's individual needs. Staff completed a range of training which was delivered face-to-face or on-line. A staff training matrix was in place and clearly showed training completed and when refresher training was required. We saw evidence that where refresher training was overdue this had been scheduled, for example first aid training.

New staff were supported with a comprehensive induction. This included several shadow shifts, working with experienced staff to get to know people and the building. One member of staff said, "It was very helpful. I got to know people and their routines. I felt safe and confident…" Another said, "I was taken under (staffs' name) wing. It was a slow and gentle beginning and I became more hands on as I got to know people…" An agency member of staff said they had received a "thorough" induction and felt confident when working with people. They added, "This is one of the better places I have worked. I can't fault them. The support has been very good."

Due to a change in senior staff at the service, staff supervision had lapsed over the past four months. This

had been recognised by the provider's internal quality assurance processes and a new schedule of one to one staff supervision had been implemented from January 2018. Staff had regular support from and contact with the registered manager and interim assistant manager. They said they were kept up to date about any changes and could speak with the managers at any time. One said, "There is always someone at the end of the phone…"

People were supported to maintain a healthy balanced diet. They were involved in planning menus and they made choices each day about what they wanted to eat, and when. Meals were freshly prepared. People were encouraged and supported to help prepare meals if they wanted to. One person explained they like to cook on occasion but enjoyed baking cakes regularly. People had access to drinks and snacks as they wished. One person was on a restricted fluid in-take due to a medical condition. Records showed staff ensure this was monitored daily and the in-take was within the required range.

People had good access to healthcare professionals in support of their rehabilitation programmes. People received support from the multidisciplinary team at The Woodmill. This included access to clinical psychology; speech and language therapist; occupational therapist and physiotherapist. People were also supported to visit their GP; dentist; optician and outpatient appointments. A health professional expressed their confidence in the service, saying referrals to them were always appropriate and staff acted on any recommendations they made. They added, "They staff are very responsive to client's needs. They recognise when people's conditions are changing and report to us. We have confidence in them (staff)".

Good

Is the service caring?

Our findings

People were complimentary about the staff and one person said they liked all of the staff. They added, "Staff perk me up! I like them and I like living here…"

Staff demonstrated a good awareness of people's preferences and needs and the best way to support them, whilst maintaining and encouraging their independence. People made decisions relating to all aspects of their care and support. For example, during the inspection one person was fully involved in menu planning and deciding how they wanted to spend their day. Choices and options were given in order to promote their independence.

Staff showed concern about people's wellbeing. For example when one person became tearful, staff immediately approached them in a gentle way. Staff were unrushed and tactile with the person, which they responded to. Staff listened and reassured and within minutes the person was relaxed and happy again. The person said, "Thank you" to the staff member.

Staff had developed positive and friendly relationships with people and we saw numerous examples of positive interactions throughout the day. There was laughter and respectful banter between people and staff. As staff knew people well, they were able to engage in conversations of interest to people, for example about their family, home visits or planned holiday. There was a relaxed atmosphere at the service, which benefitted people. People were not rushed; things were done at their pace. For example assistance with personal care. People showed signs of well-being. They smiled, laughed and engaged with staff in a happy manner.

Staff were aware of how to meet the diverse needs of people using the service including those needs related to people's disability. These needs were recorded in care plans. Staff showed an understanding of the impact on people following an acquired brain injury. For example, understanding how people's moods could change and why. Staff said they had time to spend with people one to one to focus on them and get to know their likes and dislikes and what was important to them. The provider information return (PIR) stated, "Respecting the rights of the service user including the MCA, and Human Rights, underpins all support planning…"

People were supported to maintain important relationships and friendships such as keeping in touch with and spending time with their families and friends. One person said, "I can have visitors here any time."

People's privacy and dignity were respected. Personal care was delivered in private and staff were discreet when supporting with personal care needs throughout the inspection. People were dressed appropriately and when staff noticed one person had a wet top, they immediately offered to help the person change.

People's bedrooms were decorated and furnished how they wished and according to their personal needs. One person explained they had chosen the décor and curtains in their room. They added, "I like my room…" Each person's room was personalised, people had pictures and posters and items important to them

around them.

Information was provided, including in accessible formats where needed, to help people understand the care and support available to them. For example, using alternative formats, such as pictorial images alongside written formats, with large print to make information easier to read. Information was displayed on the notice board in the entrance area including the last CQC report, Statement of Purpose and Service User Guide.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Before people moved to Spindlebury a comprehensive assessment was undertaken to ensure the service could meet the person's individual needs. The assessment and transition process also helped to ensure the personal dynamics within the small service were suitable.

People had person centred support plans which were individualised, detailed and informative. Support plans included information about healthcare needs, communication, personal hygiene, mobility and positive behaviour plans. A positive behaviour support plan is a document created to help understand and manage behaviour in adults who display behaviour that others find challenging. Staff confirmed care plans were informative and that they had time to read them. Daily notes were kept which showed how the person was feeling; any changes; what activities they had taken part and the food prepared and eaten. This gave a good sense of how the person was from day to day.

People had been involved in setting rehabilitation goals, for example, agreeing an exercise programme with the physiotherapist. One person explained the physiotherapist had worked with them to improve their mobility; however they said, "I am not very keen on it (the exercise programme)". Staff were aware of the person's reluctance and we saw them support and encourage them to engage with their exercise regime.

Staff worked with other professionals based at The Woodmill, such as the clinical psychologist, occupational therapists, speech and language therapists and physiotherapists in developing and following person centred rehabilitation support plan. The plans were reviewed regularly to ensure they continued to meet people's changing needs. People's progress or changes to needs were discussed at regular multidisciplinary meetings. The team reviewed any records relating to behaviours and incident/accidents to examine trends. This could lead to a change in a person's rehabilitation programme; a health professional referral; equipment purchase or medication review. Family and/or significant others were involved in reviews as agreed by the individual.

A daily handover meeting took place to ensure staff had up to date information about any changes in people's needs since they were last on shift. This meant staff were able to respond to how people were feeling, and to their changing health or care needs because they were kept updated about people's needs.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had detailed communication support plans completed by a speech and language therapist. Information included how the person's speech was affected by injury; how to avoid frustration for the person when speaking with them and how to promote better speech for the person. Staff communicated well with people. Using clear language and giving them time to respond.

People had opportunities to take part in a range of activities of their choice. People told us they were

supported to access the local community shops, facilities and other social events. One person said, "We go all over the place depending on how I am feeling." People were able to attend therapeutic activities at The Woodmill. For example one person said how much they enjoyed the pottery classes and had several pieces of pottery they had made on display in the room. People were supported and encouraged to get involved in light household chores, as part of their rehabilitation and to promote independence. One person spoke about their regular baking sessions and said how much they enjoyed these.

No one at the service required end of life care. Should the need arise, people's wishes would be discussed with them; their family, health and social care professionals, and staff to ensure their wishes were captured and planned for in the event of their declining health.

Information about how to make a complaint or provide feedback about the quality of the service was displayed in the hallway. People knew how to raise concerns with staff or the registered manager if they needed to. One person said, "I would speak with (staff name). She always listens to me." No complaints had been received by the service or the Care Quality Commission CQC since the last inspection.

Good

Is the service well-led?

Our findings

At this inspection, we found the service continued to be well led.

The service had a manager who was registered with CQC. 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 registered manager was supported by the interim assistant manager, who had significant experience working at the service and with people living with an acquired brain injury. People using the service knew both the registered manager and the interim assistant manager by name. They said they were able to speak with them regularly and that they listened. There had been some changes to the management structure at the service as a team leader based at Spindlebury had recently left. The provider was recruiting and in the meantime the interim assistant manager had regular phone contact with the service and visited weekly. A health professional said they had confidence in the management of service. They added, "There are not many places that can do what they do (providing specialist care for people with acquired brain injury). We have no concerns about the care. It is well managed."

The provider had a vision and strategy to ensure the delivery of good quality care and support. People's diversity and human rights were respected. Their philosophy was to ensure, "People are at the heart of everything we do. Ultimately, we want to enable our service users to participate in life as fully as possible and to enjoy as much independence as they can." We found this was demonstrated during the inspection, with people being included in all aspects of their care and daily living. The provider employed various health care professionals on its staff and they followed best practice. The Brain Injury Rehabilitation Trust (BIRT) regularly carried out research and provided a range of events and resources not only to its own staff, but to others working in the field of brain injury.

The culture within the service was positive and inclusive. People using the service described feeling safe and being well cared for by friendly knowledgeable staff. There was a relaxed atmosphere and people were able to express their needs and wishes.

The provider had effective systems in place to monitor the quality of the service. Quality and safety checks were completed by the registered manager and the provider. These included audits of health and safety issues; medicines management, and infection control. Where concerns had been identified action was taken to ensure improvements. For example, following a health and safety audit and a review of the last fire drill, the provider had decided to replace fire doors as people had taken more time than expected to evacuate the building. When medicines errors had occurred they were dealt with in an open and supportive way. Staff had received additional supervision and training and their competency had been monitored to ensure they were safe and confident in their practice.

The provider sought the opinions of people using the service. Regular reviews of people's care were held and

they were involved and feedback obtained. Regular house meetings were held to discuss issues such as menus, activities, and any concerns. One person said they could speak with any member of staff about any worries or concerns and didn't wait for meetings or reviews. Annual satisfaction surveys were completed. The information was collated and used to bring about changes. No concerns were raised in the satisfaction questionnaire responses.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. A monthly summary of accidents and incidents was completed and reviewed by the multidisciplinary team and provider for any trends. Action was taken to reduce the risk of occurrences. For example, changes in a person's rehabilitation programme or a review of equipment to aid independence and safety.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed us of significant events including significant incidents and safeguarding concerns. The most recent CQC rating was prominently displayed in the hallway area of the service.