Brain Injury Rehabilitation Trust

Kerwin Court

Inspection report

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Date of inspection visit:
09 March 2016

Date of publication:
20 April 2016

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

We carried out an unannounced comprehensive inspection at Kerwin Court on 9 March 2016. Kerwin Court provides accommodation, care and rehabilitation for up to 23 people aged over 18 with acquired brain injury. On the day of our inspection there were 19 people living at Kerwin Court. The majority of people stay for a structured time specific period of rehabilitation but some people are living more permanently at the service due to their specific needs in relation to their acquired brain injury. Kerwin Court is a purpose built building with five bungalows adjoining it. It has a courtyard garden that people can access from the inside of the building.

The service has a registered manager. 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.

People and their relatives told us people were safe living at Kerwin Court. One relative said of their family member "They are safe, I think it's faultless, I can't think of anything that could be done better". People were safe as they were supported by staff that were trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. Medicines were managed and administered safely. Risks were thoroughly assessed and planned for. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the registered manager.

We observed lunch, people had enough to eat and drink. They were given choices of food from a menu. Drinks were available throughout the day. One person told us "The foods fantastic." The service monitored people's weights and recorded how much they ate and drank to keep them healthy.

Staff were appropriately trained and supervised. Professional staff such as occupational therapist received clinical supervision and relevant training and rehabilitation support workers were supported to carry out training relevant to their roles and had received all essential training. Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation, which they put into practice.

People could choose when they wanted to get up and go to bed and were cared for by kind and compassionate staff, who knew them well. One person said "I love the place, they're so caring and considerate". People were involved in making decisions about their care and their privacy and dignity were respected.

Care plans provided detailed information about people and were personalised to reflect that person's rehabilitation programme. The care plans were reviewed regularly to reflect the person's change in need and the progress that they had made. Families were fully involved as part of these reviews. There was a range of interesting and social activities on offer at the home, which people could participate in if they

chose. People met together daily at a community meeting to share ideas and feelings and plan for the day.

The management team promoted a positive culture where person centred practice was promoted and people's rehabilitation was carefully planned and monitored. They had developed a motivated and committed team of staff. One member of staff said "The best thing here is the interdisciplinary approach with lots of joint working. I love working here. It's so supportive I can't say enough good things about it." There was a range of audit tools and processes in place to monitor the care and support that was provided. This ensured the management team were assuring the quality of the care and support provided.

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

The home was safe. People were supported by staff that recognised the potential signs of abuse and knew what action to take. They had received safeguarding adults at risk training.

People's risks were assessed and managed appropriately. There were comprehensive risk assessments in place and staff knew how to support people. Accidents and incidents were logged and dealt with appropriately.

There were enough staff and safe recruitment practices were followed. Medicines were managed, stored and administered safely.

Is the service effective?

Good

The service was effective.

People could choose what they wanted to eat and had sufficient amounts to maintain a balanced diet. People were supported to access a range of healthcare professionals.

People's consent to their care and treatment was assessed. Staff followed legislative requirements and had a good understanding of the Mental Capacity Act 2005 (MCA).

Staff had access to a wide range of training and new staff completed a comprehensive induction programme.

Is the service caring?

Good

The service was caring.

Staff knew people well and friendly, caring relationships had been developed.

People were encouraged to express their views and how they were feeling and were involved in the planning of their care.

People were encouraged to be as independent as possible

supported by a detailed rehabilitation programme.

Is the service responsive?

Good

The service was responsive to people's needs and wishes.

Care records accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes.

People were supported to take part in activities within and away from the service. People's interests were used as a way of motivating people with their rehabilitation goals.

There was a system in place to manage complaints and comments. People and relatives felt able to make a complaint and were confident that any complaints would be listened to and acted on.

Is the service well-led?

Good

The service was well-led.

There were formal systems in place to monitor the quality of the service, highlight any shortfalls and identify actions necessary for improvement.

The registered manager was fully involved in the day to day running of the home and had created a culture where there was open communication and a positive outlook.

People were asked for their views about the service and include in its development.

Kerwin Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 March 2016 and was unannounced. Two inspectors and an expert by experience with an understanding of the needs of people with an acquired brain injury undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had 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 improvements they plan to make.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the home is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We also spent time looking at records including four care records, four staff files, medication administration record (MAR) sheets, staff training plans, complaints, questionnaires and other records relating to the management of the service.

We contacted local health professionals including and a representative from the continuing healthcare team and a GP who have involvement with the service, to ask for their views. On the day of our inspection, we spoke with seven people using the service and two relatives. We spoke with the registered manager, clinical lead, two assistant managers, an occupational therapist, a physiotherapist, a team senior and two rehabilitation support workers.

The last inspection took place on 17 October 2013, where no concerns were noted.

Good

Is the service safe?

Our findings

People told us that they felt safe staying at Kerwin Court and this was described in relation to feeling at ease with staff, were able to move around the property with ease, were able to raise concerns and thought that the environment was clean and hygienic.

Staff understood how to keep people safe and one person told us "We keep everyone safe here because we operate a red flag system and assess risks they might face and carry out the guidelines for addressing the risks, we have a secure door system, have protected lunch hours and we provide person centred care". Another member of staff said "It is safe here as everyone is keeping an eye, we have good communication between service users, Rehabilitation support workers and clinicians, we carry out risk assessments and implement the guidelines".

Staff demonstrated a good understanding of what might constitute abuse, knew how to report any concerns they might have and were confident that the manager would take the appropriate action. One rehabilitation support worker (RSW) told us "Everyone here is vulnerable to abuse to a different extent but we make people safe, put them in control and offer them choice. If I suspected any abuse I would go straight to my team senior or the assistant manager to report it and would document everything factually". Staff records confirmed that training in safeguarding adults was included in the annual training provided by the service and that the majority of this was up to date. Two further courses were planned in March 2016. We noted that there were several safeguarding notices prominently displayed around the building advising people how raise any concerns they might have about abuse. The registered manager knew who to contact in the event of raising a safeguarding concern and we saw that where needed investigations had taken place and outcomes recorded.

Staff were aware of the whistle blowing policy and the need to raise any concerns about the quality of care provided or any wrong doing or suspected wrong doing with the management so they could be investigated and appropriate action taken. We saw that the whistle blowing policy was prominently displayed in the staff office, that whistle blowing was included in the induction process of all new staff and one staff member told us "I would report any suspected abuse or poor practise immediately and it would be dealt with there and then".

Staff were able to describe possible triggers for behaviours of concern. For example one staff member told us how an episode of concerning behaviour would be triggered if one person did not have their own table in the dining room. Staff were confident in their ability to respond to such incidents safely without using restraint. One member of the clinical team told us ""If someone is challenging we manage the environment and clear everyone away to keep the people safe and then rationalise with them, establish the triggers for their behaviour and give them a choice of how to proceed". Another staff member told us "If a service user becomes aggressive we make sure everyone else is safe, clear the space, lower our voice when talking with them and use language to support people to calm down. I follow the guidelines for managing behaviours that are displayed on the back of the staff toilet doors". Staff also told us that accurate recording of the episode including its antecedents, the behaviour which occurred and its consequences, was important so

that the person's rehabilitation programme could be adjusted in order to reduce the likelihood of a recurrence. We observed during a handover meeting on the day of our inspection that every incident was analysed and contributed to how the person's rehabilitation programme was managed for that day and ongoing if needed.

Detailed risk assessments were carried out with people by the clinical team and they then developed guidelines for the care and treatment of each person based on these risk assessments and their individual needs. These included risk assessments in areas such as behaviours of concern, nutrition, mobility, accessing the community, using kitchen appliances. The guidelines were used by staff to make sure they provided the people they supported, with the appropriate care. The guidelines were frequently amended by the clinical staff to take account of changes in people's wellbeing and were valued as informative by staff. One staff member told us "I always come in 30 minutes early to read the communication book, check the white board for any changes in guidelines and look at the guideline folder so when I am on the floor I am fully aware". The care records we checked confirmed that risk assessments were detailed and up to date. Daily records were easily accessible in the main office.

We were told and saw evidence that learning took place after accidents and incidents. For example a member of the clinical staff told us how they were seeking to buy a new wheel chair with rotating but non removable foot plates for one service user as they had managed to detach a foot plate during an episode of challenging behaviour. They told us that a new chair with fixed plates would have reduced the risk of a recurrence of the incident but the person really needed a chair from which they could stand by themselves to maintain their independence. Incidents and accidents were monitored on a daily, weekly and monthly basis. The management team met weekly to discuss any incidents and accidents and to analyse these for individuals and the possible impact on the dynamics of the group of people staying at Kerwin Court. Due to the constantly changing nature of the group due to people coming and going following starting and completion of their rehabilitation it was important that these changes were analysed and planned for.

A multidisciplinary team of staff provided the rehabilitation programme including assessment, ongoing rehabilitation and support to return to the community. This was made up of neuropsychology, clinical psychology, occupational therapy, physiotherapy, speech and language therapy who worked with an assistant psychologist, therapy assistants, vocational and recreational coordinator and rehabilitation support workers. Clinical staff told us that there were sufficient staff to complete their clinical work without being rushed. One member of the clinical team told us "There is lots to do here and lots to fit in but we can manage it and can rejig our programme if needed". The registered manager told us that there were enough staff to keep people safe and deliver the rehabilitation programmes needed. They said that staffing levels were constantly reviewed given the overall changing needs of people and the need for people to received one to one support. Rehabilitation support workers reported that there were not enough of them who were permanently employed at present and that the service had been using agency staff who were not as familiar with the role. The registered manager told us that they were in the process of recruiting more permanent rehabilitation support workers to enable greater consistency within the staff team.

People told us they received their medicines safely. One person said "I have a lot of medication and always get it when I should and I know what all of it's for". The service had an up to date medication policy and procedures to inform their practise. There was clear guidance on the use of 'when required' (PRN) medicines, homely remedies and the administration of covert medicines. The head of care ordered the required medication from the GP surgery on a four weekly basis and checked all prescriptions before they were dispensed by the local pharmacy. All regularly prescribed medicines were dispensed and delivered by the local pharmacist on a 28 day cycle through a monitored dosage system and they also delivered those used on a temporary basis and those used 'when required'. We saw that medicines were kept securely in the

locked medicine trolley attached securely to the wall in the drug room or in one of two additional locked cupboards in the same room. Those requiring refrigeration were kept in a separate locked fridge also in the same room. We noted that boxed and bottled medicines were in date, clean and dry with all names and dosages clear and legible.

The Medication Administration Records(MAR) were well completed and we found no gaps for signatures. The head of care told us, and records confirmed that the team seniors who administered the medicines, double checked the MAR charts after every round and signed to confirm that they were completed accurately. They also told us that they undertook an internal audit every month to check their quality and accuracy. We looked at the audit undertaken in January 2016 and noted that no improvement actions had been identified. Only trained staff administered medicines and records showed that they undertook regular face to face training to keep them up to date with any changes and records confirmed that all had completed the training in the past year. Competency checks were also carried out to make sure staff administered medicines safely.

Appropriate checks were undertaken before staff began work. We looked at staff recruitment files. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including character references, job descriptions and interview notes in staff files.
There was a requirement for all staff to complete a satisfactory probation period which included regular formal reviews of their progress, before they were employed on a permanent basis.

Good

Is the service effective?

Our findings

People told us that they were supported by staff that were skilled and knowledgeable in their different areas of expertise. One person told us "My sister said this was the best place to go they can perform miracles and they have. I can walk again. I had an x ray and they said the good news is you were intelligent before and you still are so they are helping me to get my brain working again now". Another person said "They know what they're doing and if they need to they'll find out, what more can you ask?" A relative said "They've turned [the person] around I can't praise the place enough".

Staff received an induction and training. Staff told us and we saw evidence that the general induction included an overview of the service, opportunity to read the employee handbook, fire safety, policies and procedures, use of the provider's electronic systems and code of conduct. Rehabilitation support workers (RSWs) induction included face to face and on line training, a five day period of shadowing, being observed in practice and formal probation review meetings to discuss their progress and check their skills. The assistant manager informed us that new RSWs were expected to complete the Care Certificate within the first 12 weeks of their employment. The Care Certificate is a training tool devised by Skills for Care that provides a benchmark for the training of staff in health and adult social care.

All staff undertook regular training which included health and safety, safeguarding, equality and diversity, nutrition and hydration, brain injury awareness, dignity and respect, care planning, infection control and the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Whereas training sessions on moving and handling, medication and non-violent crisis intervention were always held face to face, other topics alternated between e learning and face to face. We looked at the training plan which highlighted when training was due. We saw that where the need for refresher training had been identified the training was booked. We noted that training on safeguarding, MCA and DoLS, moving and handling, food safety and nutrition, infection control and medication where all booked to take place over the next month. The training records also confirmed that face to face non-violent crisis intervention training was included in the annual training but the assistant manager told us that this was being discontinued and replaced with training in the Management of Actual or Potential Aggression (MAPA) once the staff identified to be trainers had completed their training.

In addition we saw that staff were provided with the opportunity to undertake specific training relevant to their roles. Recent courses included safe use of ladders for maintenance staff, housing adaption designs – bathrooms attended by the senior OT, introduction to practical application of proprioceptive neuromuscular facilitation attended by the physiotherapist and social cognition by the psychologists. Monthly tutorials on specific topics were held for RSWs and ancillary staff if relevant to their role. Recent subjects included the care quality commission (CQC) inspection process and how to support service users who confabulate. The assistant manager told us that staff were encouraged to suggest topics for discussion and that some sessions focussed on the management of individuals with specific needs. Staff told us that they found these particularly useful. One RSW said "They ask us what we would like to do in our tutorials. We learn so much about individuals in the person centred ones, they are absolutely great". Staff were also encouraged to gain further qualifications and we saw, for example that a kitchen assistant was undertaking

an NCFE level 2 on diabetes, a team senior was due to start a level 4 apprenticeship and an occupational therapist had been supported to complete their MSc in neuro-rehabilitation. Comments on training included "The training here is quite good, really interactive and we are not doing things for the sake of it but because it is relevant to what we are doing"; "Training is spot on here, the best I've ever had where ever I've worked. It's so important and we need to be on the ball with everything going on here"; "Management are happy to support any training, provided we can make a case for it and it is relevant to our role".

Staff told us they were supported by their own staff teams and other colleagues within the home and felt they worked well together. Comments included "We have a really great clinical team. We work so closely and there is always someone to ask. Everyone supports everyone"; "The rehabilitation support workers know what they are on about and we can bounce ideas off them" and "Team seniors are always there to support us but everyone is happy to help and no one worries if you ask because you don't know". Staff received regular supervision and by the appropriate staff. Clinical staff received supervision from a senior member of their profession and rehabilitation support workers received supervision from one of the assistant mangers.

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. Assessments of mental capacity were in place in people's care records and where a best interests decision had been made this was recorded.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made referrals to the local authority for people living at the service that may need a Deprivation of liberty safeguard to be in place.

Staff had received training on the MCA and the Deprivation of Liberty Safeguards (DoLS) and those we spoke with understood the key requirements of the Mental Capacity Act. We noted that a copy of the DoLS policy and procedures was displayed on the notice board in the staff office. Staff were aware of people's rights to make independent decisions about their care and support and how to ensure that their legal rights were protected when they did not have the mental capacity to make those decisions for themselves.

Kerwin Court offers a rehabilitation service and due to the nature of peoples treatment several people we spoke with had to go to hospital for appointments. People had no concerns that if they became ill they knew they would be attended to. One person said "I have to go to hospital for weekly blood tests and they take me along and someone stays with me". Staff worked in close partnership with external professionals to ensure that people received all the appropriate health care. They also liaised with local authority social care teams to access move on options for people such as new accommodation or a residential care placement. The local GP visited every two weeks to review people's medicines and healthcare management. This meant that there was close scrutiny of people's medical needs.

People told us that the food was good and that there was plenty of choice. One person said "I'm vegetarian and I always get what I want". Another person said "The foods fantastic." We observed the lunchtime experience. The lunchtime was a light lunch of sandwiches and the main meal of the day is in the evening and there were two sittings for lunch. Most people came into the dining room and went to the serving area to choose from a range of different sandwiches and crisps and then chose where they wanted to sit. People that needed intermittent support were supported to by attentive staff and I didn't see anyone struggling or left in need of help. Staff were polite and offered choices of drinks including hot drinks, choices of

white/brown bread. One person wanted some tabasco sauce with their sandwiches which was happily provided. People were not rushed or hurried and the dining room was calm with people sitting either alone (their choice) or with one or two others where they chatted together.

Where needed risk assessments were completed in relation to nutritional intake. The provider used a Malnutrition Universal Screening Tool (MUST) to monitor people's nourishment and weight. MUST is a five-step screening tool that identifies adults who are malnourished or at risk of malnutrition. The tool includes guidelines which can be used to develop people's care plans. People's weights were monitored to check that they were maintaining their weight or losing or gaining weight as needed. We saw that these were completed and that food and fluid charts were completed where needed. For someone who needed to have a precise amount of fluid each day this was recorded in detail throughout the day. We saw these recordings on the daily record sheets kept in the main office.

Good

Is the service caring?

Our findings

People told us that Kerwin Court was a place with caring and capable staff. One person told us about their experience "I love the place, they're so caring and considerate". Another person said "The staff are so supportive here I'm very happy". A third person said "I was made to feel welcome the minute I got here". Relatives also said that staff were kind, caring and considerate. One relative said "All I have to do is ring them to pack [the person's] bag for me for visits home and I can totally rely on them and I don't have to check they don't miss anything". Another relative said "Staff are definitely kind and caring".

We observed that staff were patient and considerate in their approach and interacted with people in a warm and friendly way. People were supported by a named RSW and a keyworker from the clinical team who co-ordinated their care and treatment, liaised with their family and planned their discharge. Staff were committed to supporting people to achieve their rehabilitation goals. A staff member said "The best thing here is the way we look after the service users. We give them dignity, privacy and choice and the results we get speak volumes. We love to do it and it gives us job satisfaction."

Staff we spoke with knew the people using the service well. They were able to talk about their likes and dislikes, their histories, the cause of their acquired brain injury and their goals. They took these into account when providing support and when planning and reviewing their therapeutic programme. One member of staff commented "We know them [people] well and don't push them to do things they can't and don't set them up to fail".

People's privacy and dignity were respected and promoted and we noted that people had their own key to their rooms and could choose where to spend their time when not having planned activity sessions. One person told us "Even when they come and clean your room, they ask if you're happy with it. All the time they ask you to make sure you're happy. I don't like to keep being disturbed and they don't do that either, no one disturbs you". Another person said "They don't just knock on your door they always introduce themselves properly".

Staff discussed people's care needs in a respectful and compassionate way and they were able to describe how they maintained people's privacy and dignity. For example one staff member told us "We always knock on people's doors and wait to be invited in before entering and we close doors and curtains and cover them with a towel when we need to help with personal care". We observed staff to ask and check out with people, always knocking on doors, asking before going into people's rooms and we were told that private conversations didn't happen in communal areas.

The main aim of the service was to provide rehabilitation for adults with acquired brain injury who had the potential to increase their social participation and their independence. As a result people were encouraged to be as independent as possible by undertaking a rehabilitation programme including both individual and group sessions, specifically designed to meet their needs. One staff member told us "We encourage independence. We give them the tools and let them get on with it. The change in people is amazing. It is being a part of their increased independence which is so rewarding". Another said "Everyone leaves here

with some ability they didn't have when they arrived".

People were consistently involved in choices about their care and support. This was done on a one to one basis daily and as part of the care planning and review process. There was also a community meeting held every morning. We joined the Community Group on the day of our inspection. This was an opportunity for people to get together, share ideas and be empowered to share their feelings. One person led the group, another had chosen a piece of music that was then discussed, another a daily quiz question and then someone else led the daily exercises. The group together chose the film for the evenings viewing and agreed who was taking on what role for the following day. People were encouraged to talk about their progress and speak up about Kerwin Court to share any issues or concerns. During the session it was noticeable that whilst the staff supported when necessary, it was clearly the people at Kerwin Court that were being encouraged to lead the session. The atmosphere was calm with people and staff listened to each other with shared laughter and jokes. We observed people to be engaged and happy in the group. On person said of the group, "You don't have to go if you don't want to but I really look forward to it, it starts off your day and we sort out jobs for the following day". The registered manager attended this meeting every other Tuesday to answer questions and listen to any feedback about the service.

Good

Is the service responsive?

Our findings

People told us that the care and support they received was designed to meet their individual goals. People told us that staff knew them and their particular likes and dislikes. One person told us "I was a bit worried about getting around when I first got here as it was so difficult for me at hospital but no it's great and they make it easy for you. They even put up a picture of George Clooney in the dining room to encourage use of my left eye".

People received care that was responsive to their needs and personalised to their wishes, preferences and goals. A staff member told us "The care we provide is person centred. We develop individual plans for everyone depending on their individual needs and their choices".
Activity sessions were tailored to people's individual needs. We noted that they included sessions to help people improve their activities of daily living, health and fitness, communication and social skills, the understanding of their brain injury and the improved management of any associated behavioural and psychological consequences. One member of staff told us about the progress one person had made as a result of sessions focussed on helping them relearn how to clean their own teeth and another about the benefits for those attending the high level balance group from the introduction of Pilates classes. We saw there was a well-equipped training kitchen where occupational therapists carried out kitchen assessments with people and simple cookery sessions. There open access to a pleasant courtyard garden where gardening sessions were undertaken.

People were given the opportunity to attend the place of worship of their choice once they had been assessed by the clinical staff as safe to do so. Staff told us that at present they accompanied service users to the local Methodist church and to the local Catholic church and had in the past accompanied people to their Mosque. One person told us "I'm a Baptist and they take me to the Church every Sunday". There was a resource centre at Kerwin Court where people and their families accessed leaflets with information about Acquired Brain Injury and the therapies and treatment available.

People told us they were involved in their care plans. One person told us "All clinical decisions are made with my consultation and everything is thoroughly explained". Another person said "We have 12 weekly meetings which are markers, they monitor everything so thoroughly". A relative told us about the individualised nature of the care and support provided "What is amazing is that its tailored made for [the person]. They looked at what he loves and he loves exercise so it's a very can do culture and looking at what makes them and then to set goals and benchmark recovery. They've given [the person] his identity and have built us up as a family too". Care records we looked at reflected the individual needs of people and detail of the care and support needed to meet these. Individual goals and progress reports were documented. Separate daily records were kept and people's individual care needs were discussed at the handover meeting in the morning. This meeting allowed rehabilitation staff to reflect on any incidents or changes in behaviour that may indicate the need for a different approach in delivering a rehabilitation programme for a person. People's care plans reflected for example the specific detailed support they may require around managing their smoking or how a person was supported to increase strength and manage their weight by using a pedometer and accessing a local gym. People had assistive technology to support them and this

was documented in their care records. For example for one person who woke in the night and got out of bed a sensor would activate an automated message encouraging the person to return to bed. People's care records reflected their interests and used these as a focus for supporting people with their rehabilitation. For example for someone expressing an interest in running a shop they were supported to help run the tuck shop within the home to allow them the opportunity to develop skills in this area.

Alongside people's individual rehabilitation programmes there were other activities on offer such as a PAT (Pets As Therapy) dog, gardening club, karaoke, quizzes, charades, and relaxation sessions and people told us that they were never bored. Apart from individual therapies we observed people participated in board games, reading the papers and doing some bookwork for the Tuck Shop. People also told us that they enjoyed using the computer.

People were aware of the complaints procedure and told us that they would feel comfortable to raise a concern. Relatives also told us that they felt able to approach staff with any concerns. Staff were aware of the complaints policy and procedures and we noted that there was a stock of complaint forms on the notice board in the staff office. They knew what to do if someone approached them with a concern or complaint and had the confidence that the manager would take the complaint seriously. They told us they encouraged people to speak up and confirmed that people were confident to do so. One staff member told us how a person had used the complaints box in the front entrance to report their concern about the reduction in one to one support for their relative. They told us that the person was seen quickly, the reasons for the reduction discussed and a trial period for the reduction of one week was agreed with them. The staff member informed us that this had gone well and a further reduction was being planned and the person was happy with the outcome. The registered manager was fully aware of the organisations complaints procedure and we saw that they had responded to complaints in line with the procedure.

Good

Is the service well-led?

Our findings

People told us that they thought Kerwin Court was well led and managed. One person said "It's very good, everything's in place, the facilities the décor all kept in good order". Another person said "We get questionnaires to fill in and you can go and ask anything at any time." Relatives told us Kerwin Court was well managed and that the management team were approachable. One relative said "I get emails letting me know what [the person's] been doing". Another relative said there was "Excellent management".

Staff were clear on what the organisation's mission statement was 'We work with service users and their families to overcome the consequences of brain injury and enable participation in meaningful social lives. We assess factors that affect participation, we reduce risks and we help people build skills and enable behavioural changes'. We observed that staff implemented these aims on the day of our inspection.

All staff we spoke with told us that Kerwin Court was a good place to work. Comments included "This is a lovely place to work. We have a very good clinical team and the rehabilitation support workers all work well as a team"; "I love my work. It is different every day and everyone improves in some way while here partly because of us" and "The job is busy and buzzy with lots of variety and the best thing is we see people making progress and getting better. People can come in in a wheel chair and walk out of the door". They were positive about the quality of permanent staff working in the home. One said "We have great staff and the rehabilitation support workers are fab. They really understand the role of rehabilitation". Another told us "We have a very good clinical team and the RSWs are very helpful and co-operative and we have good two way communication".

The registered manager was fully involved in the day to day management of the home and we observed her chairing the handover meeting at the beginning of the day and she demonstrated a detailed knowledge of every person who was living at Kerwin Court at that time. The registered manager told us that the culture of Kerwin Court was "A no blame, learning culture where everybody has a role to play and is important" The registered manager told us that people were at the centre of the care and support provided at Kerwin Court and that they worked with the person's family and networks to achieve people's goals. People and staff told us this and we observed this to be the case on the day of our inspection.

The registered manager had been in post since 2010. The registered manager worked alongside the clinical lead for the service and staff told us that the management team were cohesive and supportive. One staff member said "The manager is strong and good to talk to and when the chips are down she is there": "The manager is very approachable, co-operative and helpful" and "The manager is good at keeping us up to date. You can ask her advice on personal matters and she is helpful".

The registered manager used a variety of systems to monitor the quality of the service provided at Kerwin Court. Staff told us that they had regular staff meetings and the management listened to any suggestions for improvement they made. For example one staff member told us how, their suggestion to improve the discharge process with the use of a discharge checklist form, completed and signed the day before discharge, had been adopted by the registered manager and successfully introduced. We also saw that

there were a series of meetings held with the aim of ensuring detailed oversight of the quality of care and support provided. Extraordinary Clinical Business meetings which a focus on specific topics or areas that could be developed and a weekly clinical meeting attended by the Management team, Clinical lead and Therapists. The service held a bimonthly clinical governance meeting. Minutes of these meetings were recorded and available to view.

There was an annual Program of monthly Internal quality assurance audits completed at the service including areas such as nutrition, hand washing and participation. A summary report was sent to the provider's quality assurance department. The provider carried out an annual quality assurance audit and we could see that one had very recently been carried out. The registered manager was in the process of devising an action plan following this which included areas such as increasing supervisions for the Rehabilitation Support workers (RSW).

In October the registered manager had organised a quality week where surveys that captured people's opinions of their experience at Kerwin Court were carried out giving people the opportunity to feedback and be involved in the development of the service. These surveys had pictorial prompts to enable as many people as possible to participate in questionnaires. The results of these surveys were analysed and the results were recorded and displayed around the service. As a result of this pictures of the management team had been put up so people could identify who the managers were. The provider also carried out annual questionnaires that were sent out from the head office. Staff surveys were also carried out and we saw that as part of this staff were asked to put themselves in people's shoes and to identify when they had supported a person with something that mattered to them. This enabled staff to identify what was important to people and to remember that little things such as being able to replace a computer or put make up on in the morning that made a difference to people's wellbeing.

The service worked closely with Clinical Commissioning Group commissioners to ensure a clear referral and discharge pathway doe people who used the service. Regular review meetings were held with commissioners to ensure clear rehabilitation goals were being met. The management team worked closely with GP's, Community Rehabilitation teams, Acute settings, District nurses and the Consultant in Rehabilitation Medicine. Professional we contacted were complimentary about the care and support provided. One professional said "It is well led and managed by [the clinical lead] and [registered manager]. The level of care is excellent and well-co-ordinated across the multi-disciplinary team".