Bristol City Council

Bristol South Rehabilitation Centre

Inspection report

30 Inns Court Green
Knowle
Bristol
BS4 1TF

Tel: 01179038392

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 December 2017 and was unannounced. The service was registered to provide accommodation and personal care for up to a maximum of 20 people over the age of 18 (only 18 beds were in use). At the time of our inspection there were 10 people in residence. This is a rehabilitation service, jointly funded by Bristol City Council (registered provider) and Bristol Community Health. Rehabilitation services are provided for up to six weeks in order to support people who are medically fit to be discharged from hospital but need further therapy. The service may also be used to prevent a hospital admission.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

After the last inspection in June 2016 we rated the service overall as Requires Improvement. We had identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had then sent us their action plan which detailed the improvements they would make.

As part of this inspection we have checked to see that these improvements were made and sustained. We have now rated the service as Good and there were no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were safe. Staff knew what to do if there were concerns about a person's welfare and had received safeguarding adults training. Risk assessments were completed as part of the care planning process. Where risks were identified there were plans in place to reduce or eliminate the risk. Each person had a written personal emergency evacuation plan detailing the level of support they would need in the case of an emergency. The risks of employing unsafe staff were reduced because of robust staff recruitment procedures.

The premises were well maintained. Regular maintenance checks were completed to ensure the building and facilities were safe. Checks were also made of the fire safety systems, the hot and cold water temperatures and equipment to make sure they were safe for staff and people to use. The premises were clean tidy and fresh smelling.

Staffing levels were calculated and based on the collective needs of each person who was using the service at that time. This ensured the staff were able to meet all care and support needs safely. Medicines were managed safely.

The service was effective. New staff completed an induction training programme at the start of their

employment and any new-to-care staff completed the Care Certificate. There was a mandatory training programme for all other staff to complete to ensure they had the necessary skills and knowledge to care for people correctly.

The mental capacity of each person to make informed decisions was assessed on admission to the centre and then reviewed. People were involved in making decisions and encouraged to make their own choices about their care and support. The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were provided with sufficient quantities of food and drink. They were supported to regain life skills in order to enable them to return home and be able to look after themselves. There were arrangements in place to ensure people were temporarily registered with a local GP during their stay. The service worked in partnership with other healthcare professionals who supported the people using the service.

The service was caring. Staff had good working relationships with the people they were looking after and were committed to their role of rehabilitation. The person was the focus of all decisions made about their care and they were listened to. Any suggestions they made were acted upon.

The service was responsive. People were provided with a personalised care and support service that met their specific needs. The aim of the service was to rehabilitate them after a period of ill health and enable them to return to their own home.

The service was well led. The staff team was led by a registered manager and an assistant manager. They provided good leadership and management for the staff team. Staff meetings ensured they were kept up to date with changes and developments in the service.

There was a regular programme of audits in place, which ensured that the quality and safety of the service was checked. These checks were completed on a daily, weekly or monthly basis.

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 remains safe,

Is the service effective?

Good

The service was effective.

Staff were trained and well supported enabling them to carry out their role.

The service was aware of the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and worked in accordance with this. People were asked to consent before staff helped them with tasks.

People were provided with sufficient food and drink and were able to make choices about what they ate and drank. They were assisted by healthcare professionals and involved in the planning for when they moved from the service.

The premises were appropriate for the purposes of the service provision.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service was well led.

There was good leadership and management in place. People's views and experiences were seen as paramount to the success of the service. Staff were well supported.

There was a programme of checks and audits in place to ensure that the quality of the service was measured. The registered manager planned to improve administrative systems to make access to records easier.

Bristol South Rehabilitation Centre

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.

The inspection was unannounced and was undertaken by one adult social care inspector.

Prior to the inspection, we looked at the information we had received about the service since January 2017. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us.

During our inspection we spoke with eight people and two visitors. We spoke with the assistant manager (the registered manager was on leave), three rehabilitation support workers (RSW) and one health and social care assistant (HSCA). A health care provider also had input into the care of people who used this service and we spoke with one nurse and one occupational therapist.

We looked at four people's care files and other records relating to their care. We looked at staff training records, key policies and procedures, completed audits and other records related to the running of the service.

Good

Is the service safe?

Our findings

People said they felt safe whilst they were staying at this service. The comments they made included, "It is alright here. I fell before I came here, my mobility is not very good so they are watching me when I walk and giving me advice", "The staff check in on me regularly at night to make sure I am OK", "They (the rehabilitation staff) are introducing different mobility aids so I will be safer walking" and "It is good here, I have never seen anything bad happen".

People were safe because they were protected from bullying, harassment, avoidable harm and abuse. All staff completing safeguarding training as part of the mandatory training programme, knew about the different types of abuse and knew what action to take if abuse was suspected, witnessed or a person made an allegation of harm.

There were effective safeguarding systems in place. A paper copy of the provider's Safeguarding Vulnerable Adults from Abuse policy was kept in the main office with the newest version of this being on-line. Staff had access to this if needed. Staff said they would report any concerns they had to the registered manager or assistant manager but knew they could report directly to the local authority, the Police and Care Quality Commission. The service had raised one safeguarding concern with the safeguarding team at Bristol City Council in the last year regarding the safety of a person they looked after and a family relationship.

Risk assessments were completed for each person who used the service. These included a moving and handling risk assessment, a nutritional screen, an assessment of the likelihood of sustaining pressure ulcer damage to skin and a falls assessment. Where a person needed assistance to move or transfer from one place to another, a mobility plan was written, setting out the equipment to be used and the number of staff required.

Upon admission to the service a personal emergency evacuation plan (a PEEP's) was prepared for each person. This set out the amount of support the person would require in the event of a fire and the need to evacuate the building. A copy of this was kept in each person's care file and also along with all the other PEEP's and fire safety information.

The service employed a handyman who had delegated responsibility to undertake a programme of maintenance checks. These included fire safety checks, hot and cold water checks, and visual checks of the premises and equipment. These checks ensured people were cared for in a safe place and also the staff were not placed at risk. The provider had safety advisors who completed six monthly safety checks and any concerns were always discussed in health and safety committee meetings. The kitchen staff had cleaning schedules, freezer and refrigerator temperature checks to complete and complied with safe food storage arrangements. Domestic staff had daily, weekly and monthly cleaning tasks to complete. These measures ensured people lived in a safe and clean environment.

The dependency score for each person was updated on a daily basis in order to determine safe staffing levels. Staff confirmed that staffing levels were adjusted when the workload increased and people's needs

changed. Catering staff, domestic staff and allied healthcare professionals employed by the healthcare provider (joint partnership working) were also on duty to meet people's daily living and health care needs. Staff had the right mix of skills to make sure practice was safe and they were able to respond to unforeseen events.

We were unable to check staff personnel files to ensure the service followed robust recruitment procedures because these were kept at Bristol City Council headquarters. We have previously spoken to their recruitment department. They advised us pre-employment checks included written references, a health questionnaire to ensure staff were fit for the job and an enhanced disclosure and barring service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The measures that were in place significantly reduced the chance of unsuitable staff being employed..

On admission to the rehabilitation centre the level of support each person required with their medicines was determined. There were suitable arrangements for ordering, receiving and disposal of medicines, including those requiring extra security and recording. People's medicines were stored securely in locked cupboards in their bedrooms. Staff recorded the administration of medicines on medicine administration record charts. Those we looked at were accurate and complete. During each person's short stay they were continually assessed. Where appropriate they were supported to manage their own medicines. Where a person needed to be supported with a package of care in their own home following discharge the service handed over information during the transfer of care process.

All areas of the service were clean, tidy and fresh smelling. All staff received infection control training as part of the mandatory training programme. Regular checks were undertaken of the environment and rooms were deep cleaned before new admissions were arranged.

Good

Is the service effective?

Our findings

We asked those people being supported by the service at the time of the inspection if the service was meeting their expectations and received overwhelmingly positive feedback. They said, " I was worried that after a fall I was not going to be able to live in my own home again, but the staff have worked really hard with me to make my mobility better", "All the staff have worked really hard with me so I can go home again" and "Since I have been here my health has really improved. I am waiting to go and live in a care home though because I would not manage at home again".

Admissions to the centre were managed by the admission team and the bed manager. The registered manager ensured the centre staff had the capacity to meet the person's needs prior to any admission being arranged. These measures ensured the service was effective for every person who was admitted.

The effectiveness of the service was measured in assessing how the goals set for each person were achieved. Weekly multi-disciplinary meetings (MDM) were held to discuss how plans were progressing. These meetings were led by the registered manager and attended by occupational therapists, physiotherapists and a nurse from Bristol Community Health (BCH). Rehabilitation support workers (RSW) and care staff attended in order to feedback how the rehabilitation programme was progressing. These measures ensured people received the care, treatment and support they needed and met their needs.

Staff were regularly supervised by the registered manager or assistant manager. Their work performance and rehabilitation role was overseen by the healthcare professionals from BCH. The training and development needs of the staff team were kept under review and any training was organised as and when necessary.

At the start of each shift the staff coming on duty received a full handover report from the staff going off duty. These arrangements meant staff were made aware of any changes in people's care and support needs.

New staff to the service had an induction training programme to complete at the start of their employment. Some of the training was corporate induction whilst other training was role specific. Because of the rehabilitation nature of their service, staff who were experienced social care workers were generally recruited. Any new- to- care, care staff would complete the Care Certificate within 12 weeks of the start of their employment. The Care Certificate was introduced in April 2015 and covers a set of standards that social care and health workers must work to.

There was a programme of refresher training for all staff to complete. This included moving and handling, safeguarding adults, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safe medicine administration, health and safety, dementia awareness and basic life support. When we inspected in June 2016 we found that not all staff were up to date with their training but those we spoke with during this inspection confirmed they had completed all the required training. Electronic staff training records were kept however on the day of inspection these were not up to date. The registered manager provided up to date records after the inspection. Person specific training could be arranged if necessary and staff were

able to work closely with the allied healthcare professionals. These measures ensured staff had the skills and competencies appropriate to their role.

People were assessed in respects of how much support they needed with preparing meals and drinks. Each person was assessed in order to identify any risks in respect of nutrition and hydration. This was then reviewed on a weekly basis. The level of support each person needed would be recorded in their care plan and reviewed on at least a weekly basis. The aim of the service was for people to regain skills they may have lost during a period of illness or a hospital stay. The service had kitchen areas where people could work with the staff or healthcare professionals to make hot meals and hot drinks. They were assessed for any equipment needed to enable them to manage when they went home. Whilst people were being looked after in the rehabilitation centre they were provided with three meals a day. There were choices of meals and healthy food options were always available.

People using the service were temporarily registered with a local GP if their own GP was not in the nearby vicinity. When people were temporarily registered with this GP, the medical centre obtained a medical history from the person's own GP. This GP visited the centre on a weekly basis and reviewed people's healthcare needs. The service had clear systems in place for referring people to external services when required and the person was always involved in planning their move, either to their own home, or on to residential services.

The premises were suitable to the type of service provided. Each person had their own bedroom. For those people who required moving and handling equipment to be used the bedrooms were larger. The service was well equipped with profiling beds, raised toilet seats, moving and handling equipment and various aids for independent living. In addition to the bedrooms there were communal lounges, dining rooms and assisted bathrooms.

Staff were aware of the need to ask for people's consent and we heard them asking people for their agreement before providing any care. An assessment of their capacity to make informed decisions was made and they were encouraged to say how they wanted to be looked after. Their preferences were respected. Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. We discussed with the assistant manager an application to the local authority that had been made for one person when they had been admitted. The assistant manager demonstrated their awareness of the legislation.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. The staff treated them with dignity and respect and involved them in all care planning and decision making. One person said, "The staff are all very nice and kind. The plan is for me to get home". Another said, "I have been shown nothing but kindness. I have not seen anything or experienced anything bad here".

We looked at a selection of the complimentary cards and letters received by the service. Comments included, "I am so grateful to (named carer) for all your kindness which I am sure helped me get better quicker", "Thank you for being so cheerful and caring", "Thank you for your kindness and the care you gave to (named person)" and "I went back home feeling a new person because of your hard work".

Staff in the rehabilitation centre were knowledgeable and supportive of the people they were assisting. People were included in discussions about their care and were encouraged to express their views and make decisions for themselves. The staff ensured that people were given time to make informed decisions. The staff we spoke with knew people's individual care needs, their social set-up and their goals for independence.

We observed that the staff team had good working relationships with people and treated them with dignity and respect. Communication was friendly and caring. Staff had the right skills to make sure that people received compassionate support and had enough time to get to know them. Personal care was always provided in private and the staff made sure that toilet, bathroom and bedroom doors were closed when they were attending to people. Staff responded promptly when people needed help or reassurance and we saw one member of staff reassuring a person who was anxious about returning home.

Those staff we spoke with understood people's needs and demonstrated they knew how people liked to be looked after. The staff understood the importance of supporting people to regain life skills to enable them to continue living in their own homes.

People and their families were provided with information about the service and there was a range of leaflets available regarding on-going care and support. In each of the bedrooms there was a folder containing a copy of the statement of purpose and service user guide. These set out the facilities available in the centre and informed people what they could expect. Included was a copy of the complaints procedure should they be unhappy about any aspect of their care and support. Although the information was provided in written format, the provider had the ability to produce information and leaflets in alternative formats.

Good

Is the service responsive?

Our findings

People said, "I want to be back at home. They are getting me back on my feet so I can manage", "I didn't believe I would ever be able to go home but against all odds I can walk better now. The staff have been marvellously helpful" and "I cannot fault the care I have received".

People's care, support and rehabilitation needs were assessed prior to admission to the centre. This was generally undertaken by healthcare professionals working in a hospital setting. However, some people were admitted for rehabilitation to prevent them needing a hospital admission. This ensured the service was the right place for the person and that rehabilitation was achievable. The assessment also ensured any specific equipment was available. The information gathered during the assessment process was used as a basis for their plan of care.

Each person had a plan of care prepared for them and these set out their specific care and support needs. Each person received personalised care taking in to account their whole life and living arrangements. The person was involved in making decisions about how they were looked after. The assessments and care plans provided a good picture of the person, their care and support needs and their goals to regain independence. During the person's stay the care plans were adjusted as often as necessary. The rehabilitation support workers and care staff worked in conjunction with the physiotherapist and occupational therapist in order to meet people's needs.

People told us if they had any concerns or were unhappy about any aspects of their care they would feel able to raise these with any of the staff team. The provider had a complaints policy and procedure in place and a copy of this was displayed throughout the centre. We looked at the complaints log and no formal complaints had been recorded since 2014. The policy stated that any complaints would firstly be responded to by the registered manager but if unresolved, would be dealt with by the registered provider (Bristol City Council).

Due to the nature of this service, end of life care is not provided. People using this service are provided with a short term rehabilitation service. The maximum length of stay was six weeks although some discharges from the centre may be delayed because of waiting for community support to be arranged or residential placements.

Good

Is the service well-led?

Our findings

People told us the service was well run and the senior staff provided good leadership for the staff team. The staff team were led by a registered manager plus there was an assistant manager. The care team consisted of rehabilitation support workers and care assistants and they were supported in meeting people's daily living needs by catering and housekeeping staff. As this was a joint funded service along with Bristol Community Health (BCH - another care provider), people were also attended to by occupational therapists, physiotherapists and social workers. The two services worked in partnership to ensure people were rehabilitated to return home or to reach their maximum potential.

The aims of the service were clearly stated and all staff worked towards getting people back to their own homes. When this was not possible, they worked with other services to ensure people received good outcomes. Each person's care and support needs were reviewed each week in a multi-disciplinary meeting with the occupational therapists, physiotherapists, social workers and nurses. The plans for each person were discussed along with the arrangements for any on-going community support.

When we inspected the service in June 2016 shortfalls had been identified in relation to care records maintained by the RSW and care assistants. There were gaps in some people's notes and some care documentation had not been completed. We looked at four people's care records. Whilst we did not find any omissions we did note that the daily records of care did not evidence the progress being made in the person's rehabilitation plan and we brought this to the attention of the registered manager for their attention.

Staff meetings were held regularly and staff were encouraged to make suggestions. The last meeting with the RSWs had been held in November and previous to that in July 2017. The registered manager attended centre managers meetings. These meetings enabled the staff team to share what had gone well and not so well with the other managers and to learn from their experiences. Outcomes of Care Quality Commissions inspections were shared between the various services.

The provider had a quality monitoring system in place to ensure the quality and safety of the service was maintained. Audits were completed in respect of health and safety every six months. Audits were also completed in respect of medicines. Where people were admitted with supplies of their prescribed medicines, the amounts were recorded and then checked on a weekly basis throughout the admission. People's care records were checked at the end of their stay in order to identify where improvements could be made.

The registered manager submitted monthly reports to their line manager in respect of how the service was performing. They had to supply information regarding any safeguarding alerts raised, complaints received, any accidents and incidents, staffing issues and a 'bed summary'.

Feedback questionnaires were used at the end of a person's stay in the rehabilitation centre to gather feedback from them. The information gathered in this process was used to make any improvements by

acting upon suggestions made by people who had used the service.

The registered manager and team leader were aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled.

All policies and procedures were kept under regular review. Staff were able to access the policies from the policies manuals in the main office however a lot of them were old policies and had been replaced by up to date policies. Electronic versions were available and staff did have access to these.

We had a discussion with the registered manager regarding some of the paper records kept in the main office. There were many records that related to previous years. This made it difficult to locate recent records on occasions. The service had been without an administrator for some time but a new member of staff would be starting in the new year. The registered manager was aware of this shortfall and had marked this as a priority task to be completed.