Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Brendoncare Knightwood

Shannon Way, Chandlers Ford, Eastleigh, SO53 4TL

Tel: 02380247000

Date of Inspection: 23 September 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Staffing ✓ Met this standard

Details about this location

Registered Provider	The Brendoncare Foundation
Registered Manager	Mrs Nicola Toomer
Overview of the service	Brendoncare Knightwood is a short stay service for up to 17 people discharged from hospital, to enable them to regain independence. In addition there are three rooms for people who require respite care. The unit provides post-operative and medical rehabilitation, and is part of a larger complex comprising bungalows and apartments for older people. Within the complex the service is known as The Dame Sheila Quinn Unit.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Brendoncare Knightwood had taken action to meet the following essential standards:

- Staffing

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 23 September 2014, observed how people were being cared for, talked with people who use the service and talked with carers and / or family members. We talked with staff.

What people told us and what we found

We carried out this inspection of Brendoncare Knightwood (the service) in order to follow up a requirement we made following our last inspection of the service on 5 November 2013. On that occasion we found there had not always been a sufficient number of staff with appropriate mix of skills and experience, available to meet people's needs.

On this occasion we found there were arrangements in place that ensured staffing levels were sufficient to meet people's needs.

At the time of our inspection there were nineteen people accommodated at the service, sixteen were in receipt of intermediate care and three were receiving a respite service. We spoke with twelve people of the nineteen people in order to hear what they had to say about the deployment of staff at the service.

We also spoke with a six staff including the senior nurse manager and three visitors to obtain their opinions about the staffing of the service.

During our inspection we spent 45 minutes in the service's dining room and observed the routine during the lunch meal.

We also looked at records and documents concerned with the deployment of staff such as training records, rotas and data about the dependency levels of people who used the service.

The evidence we gathered against the outcome we inspected helped us answer our key question.

Is the service safe?

Below is a summary of what we found.

If you want to see the evidence supporting our summary please read our full report.

Is the service safe?

The service is safe because there are enough qualified, skilled and experienced staff available to meet people's needs.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff available to meet people's needs.

Reasons for our judgement

At our last inspection of the service on 5 November 2013 we concluded there were insufficient staff available to meet people's needs. This was because on three occasions agency staff used to cover the absence of permanent staff had failed to arrive for their shifts. People had told us responses to the service's call system to requests for help had not been timely. We also found that on one occasion the two night staff on duty in the service were both agency or temporary staff.

Our discussions with people accommodated at the service, visiting friends and relatives and members of staff produced no consensus about the sufficiency of staff levels. Some people thought there were enough and others thought there should be more. One person described the staff response to requests for help as "prompt". Another person told us they thought staff had taken a long time to answer a request for help they made on one occasion. People who used the service did however accept they sometimes had to wait for assistance because could be busy helping to meet other people's needs.

Some staff we spoke with expressed a view that a registered nurse and health care assistant on duty at night was not enough. They said this because some people required the assistance of two staff because of their dependency levels. They also said because the registered nurse on duty had the responsibility of giving out medication, if a person requested assistance and this had to be provided by two staff, their help could be delayed.

Following our last inspection the service's registered manager, who has since left, sent us an action plan. The plan set out the actions that had been taken to ensure compliance with the legal obligations imposed on the provider concerned.

On this inspection we saw the action plan had been implemented.

We saw documents that showed staff had been informed of the importance of responding

promptly to the call system. We also saw an analysis of the use of the system and response times had been carried out for a period from December 2013 to April 2014. It showed response times had improved. This showed there was a system in place that could monitor the timeliness of responses to requests for help and enable enquiries to be made where it showed people had to wait an unduly long time for assistance.

The senior nurse manager told us that where records showed a long response time they were "Almost certainly where the alarm has been acknowledged with the patient but not cancelled. This is unfortunate as it gives a longer response time on the data and is something we have been reminding staff to ensure they do correctly".

We also noted the time a call point was activated and subsequently responded to was displayed on a monitor in the service's nurses station. This enabled the respective times to be checked if a person felt their request for help had not been timely.

During our inspection we found one of the alarm call points was not working. This was because it required a new battery. A member of staff had been aware of this and the battery was replaced almost immediately.

Staff told us some of the call points, which are like wrist watches and worn by people, required repair. They said this was causing some problems because there were only a limited number of spares. The senior nurse manager and the manager of the complex in which the service was located told us this matter was being addressed without delay.

We saw a document that showed at night staff routinely checked the welfare of people at least every hour. This meant in the event a person was too unwell to use the call system to request help, or there was a fault with the system, the maximum length of time they had to wait for help was an hour.

People we spoke confirmed staff checked on them very frequently at night. One person said, "They are always sticking their heads round the door to see if I am OK". Another person said, "I thought I did not sleep very well but they tell me every time they check on me I am snoring".

Staff we spoke with confirmed that since our last inspection the two staff on duty at night had always included at least one permanent member of staff. This meant that at least one of the two staff on duty would be familiar with routines and operation of the service and more importantly the needs of people accommodated there. The senior nurse manager also told us that they would ensure there was always at least one permanent member of staff on duty at night.

The senior nurse manager told us they no longer used the services of the agency that had supplied them with temporary staff to cover absences, they were using at the time of our last inspection. They said they believed that agency had accepted requests to supply temporary staff before they checked whether they had the ability or capacity to do so. The manager told us they had a new arrangement with a more reliable agency. They said agency staff had not failed to arrive for their duties since then. They also told us they attempted to implement strict admission criteria, so the number of people accommodated at the service that required the assistance of two staff to meet their needs did not exceed three to four at any one time.

We were also made aware by the senior nurse manager and other staff that since our last

inspection arrangement had been made for an extra healthcare assistant to be on duty every Wednesday between 11:00 a.m. and 1:00 p.m. They said this had been done because a multi-disciplinary meeting took place at that time and it required the attendance of a member staff who would otherwise be available to help and support people. Staff we spoke with said consequently this had enhanced their ability to respond to people's needs during that time.

Staff rotas we looked at showed that on occasions some staff on early and late shifts were scheduled to start earlier and finish later than their colleagues. The senior nurse manager told us that members of staff had agreed to work flexibly and provide an overlap to enable more staff to be available at busy times of the day when there were the number of people who required the help of two staff to meet their needs had exceeded four.

We observed the lunchtime meal served in the dining room at Brendoncare Knightwood. We noted that fourteen people were present and three healthcare assistants available to serve meals and help people if required. Other people had chosen to eat in their bedroom accommodation. There was no delay in serving meals and anyone who requested assistance with matters such as with cutting up meat or the pouring of a drink was responded to quickly.

At the time of our inspection the senior nurse manager told us there was a vacancy on the staff team for a registered nurse for two nights a week. They said other nurses who worked at the service "Picked up extra shifts" and if required they used regular agency staff who knew how the service operated.

We looked at a sample of eleven questionnaires completed by people who had used the service between April and September 2014. There were no comments in any of the responses to indicate the staffing level and skill mix at staffing was inadequate.

We looked at a staff training matrix and it showed staff completed a range of training courses including, dignity, infection control, manual handling, medicines management, safeguarding, first aid, health and safety, food hygiene, nutrition, Mental Capacity and deprivation of Liberty Safeguards, Dementia and tissue viability.

This all showed there were enough qualified, skilled and experienced staff available to meet people's needs

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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