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: 30 January 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	The Brendoncare Foundation
Registered Manager	Mrs. Susan Clare Porter
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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 January 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

We looked at care plans for four people. We observed people being supported by staff, spoke with five people in private, and one relative. We saw that people's privacy, dignity and independence were respected.

We spoke with five staff, including nurses, carers, a rehabilitation assistant and a volunteer. Three staff told us the strength of the service was the good team work. One member of staff said they enjoyed "providing holistic care for people".

All five people told us they liked it at Brendoncare Knightwood. People said "It's really nice here", "It's marvellous", and "The staff are good".

Individual needs of people were assessed and were continually reviewed, and care plans updated. People experienced care, treatment and support that met their needs and protected their rights.

We looked at safeguarding arrangements for staff training, talked to staff and people who used the service, and reviewed care plans. We found that people were protected because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Staff rotas, staff training records, observation of staff supporting people and discussion with people demonstrated that there were enough qualified, skilled and experienced staff to meet people's needs.

The provider had in place effective systems to assess and monitor the quality of service, which sought people's views, and learnt from investigations into incidents.

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

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

The purpose of the service was to promote people's independence. This was reflected in care plans, confirmed through discussion with people who used the service and staff, and from observation.

We observed that the provider ensured people understood their care. The unit manager told us the aim of the unit, to provide rehabilitation services, was explained to people when they were admitted, so that people had realistic expectations. The manager and staff told us it was important that people understood this was not long term care. People using the service told us the unit manager and staff explained and discussed their care and support with them. We saw evidence of this in people's care records.

We saw that each room contained an information pack for people, which stated the aims of care and that, in using the service, people agreed to actively participate in their rehabilitation. In addition to information about the service provided, the information pack included nutrition guidance, in order to encourage people to maintain their health through good nutrition and hydration to aid their rehabilitation. All the people we spoke with understood that the aim of their care was to enable them to regain their independence on leaving hospital, to prepare them for returning home.

We observed unobtrusive ways in which the service encouraged people to be mobile, and thereby more independent. For example morning coffee and afternoon tea were served in the lounge for people if they chose, rather than in their rooms. Daily newspapers were available in the lounge, and we saw that this encouraged people to move out of their rooms.

We saw that staff made adjustments to the usual arrangements in order to meet individual needs and wishes. For example, we were told by the unit manager that people had breakfast in their rooms, and lunch and tea were served in the dining room. This was to ensure that staff could observe and assess whether people were eating, and whether they needed additional support to do so. It was also a way to encourage mobility. We saw that there was some flexibility, however. One person told us they found it uncomfortable in the

dining room, and they were able to have all their meals in their room by agreement.

We observed that staff promoted dignity when supporting people and talking to them. A volunteer told us that they considered this was of paramount importance. One person who was using the service was also of this view. They said that after staying in hospital, where you could maintain little dignity, they had "got my dignity back".

We observed that staff promoted people's privacy while supporting them in their care, by ensuring doors were closed. We saw that staff knocked and waited before entering, whether or not the door was open. The design of the rooms promoted privacy, as the sleeping and sitting area were not in direct view when the door was open. One person told us how staff were always careful to preserve their modesty with a towel when supporting them with personal care.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

The assessment, planning and delivery of care and support was centred on the person and considered their individual circumstances and their immediate and longer-term needs. Healthcare services such as physiotherapy, occupational therapy and access to a GP and consultant were available on site.

We saw care records for four people who used the service. The unit manager told us the criterion for admission was that people should be completely medically stable, in order that rehabilitation support could be effective. Referrals to the service were made from hospitals, which provided a discharge summary. We saw that referrals varied in the information given, and the unit manager told us they would follow it up where information was scant or ambiguous. We saw from the documentation that this was the case.

The files demonstrated the provider undertook a full assessment of need when people were admitted to the unit. Assessment tools were used to establish a baseline level of how people were functioning, and to measure improvement over time.

The individual goals were clearly identified for each person. For example, we spoke with one person who was admitted the previous day and their spouse, and saw their file. The aim of care was identified as to walk with a mobility aid. Both people were clear that this was the goal and that this was a short term placement.

From the care records we saw that the provider had a system to continuously review the care and support needed. We saw areas such as nutrition and tissue viability were monitored by staff, records kept, and care plans updated as required.

We saw from the care records how the provider promoted people's independence whilst minimising risk. Risk assessments were undertaken, in areas such as falls, and moving and handling. Risk management was incorporated into support guidelines. For example, these detailed how people were to be safely supported to become mobile.

This demonstrated that the provider ensured safe, consistent and effective personalised care and support through coordinated assessment, planning and delivery.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People we spoke with told us they felt safe at Brendoncare Knightwood and said they felt able to raise concerns with the manager.

We saw training records for all staff, which showed people received regular training in safeguarding. We spoke with five staff, including care staff, nurses and a rehabilitation assistant. All confirmed they had undertaken training and demonstrated through discussion they understood their responsibilities in relation to safeguarding and knew what action to take in the event of an allegation or suspicion of abuse.

We also spoke with a volunteer, who had not received formal training in safeguarding. The volunteer was clear about the action they would take in the event an allegation or disclosure of abuse.

A copy of the local authority multi-agency safeguarding procedures was available with the provider's procedure, which made clear how concerns should be escalated. The policies and procedures were accessible to staff, and there was a prominent flowchart on the office wall. From supervision records we saw that supervisors check staff member's understanding of safeguarding.

We saw that there was a clear procedure for notifying the relevant authorities of safeguarding matters, so that all staff would complete incident forms, but the senior staff would make the notification to the local authority where required. We reviewed records that showed it was practice at the unit to make notifications tothe local authority and the CQC when a person was admitted from hospital with pressure sores or areas of damaged skin, in order to safeguard people.

We tracked the notification process for one person who used the service. This demonstrated how concerns are recorded and followed through, to protect people using the service. Records were held on a central secure database, to enable the provider to monitor incidents, and this detailed action taken and outcomes. The person was admitted to the unit with a grade 4 pressure sore on their heel. The unit manager notified the local authority and the CQC in accordance with the safeguarding procedure. The social worker had undertaken a mental capacity assessment, and a referral made to a tissue viability

nurse.

This demonstrated how the provider ensured people who used the service were protected from abuse by having effective safeguarding systems in place.

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 to meet people's needs.

Reasons for our judgement

People who used the service were safe and had their care needs met by sufficient numbers of appropriate staff with the right skills and knowledge.

We saw how the unit manager had a system in place to review and update staffing levels in the light of people's changing needs.

The minimum staffing level was two nurses and three or four carers in the morning, two nurses and two carers in the afternoon and evening, and one nurse and one carer at night. In addition to nurses and carers the level was enhanced by the physiotherapist, occupational therapist, rehabilitation assistants, a volunteer morning and afternoon, the unit manager and registered manager.

We saw from rotas how the unit manager increased the staffing level as required in order to ensure people's safety. For example, from 27 November to 2 December additional staff were provided for twilight shifts. The manager told us how they monitor people's dependency so that people would be admitted for respite only if it was safe to do so.

This demonstrated that the provider carried out a needs analysis and risk assessment as the basis for determining sufficient staff levels and adapted these levels as a result, thereby safeguarding the welfare of people who used the service.

There was a bank of staff who provided cover, and we spoke with one bank nurse. We saw that, where it was necessary to deploy agency staff, the same staff were used. One agency nurse was working at the time of the inspection, and we observed that they were familiar with the service. This demonstrated how the provider ensured consistency of care.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We reviewed the systems in place for monitoring the quality of the service provided.

There was a system in place for regular audits, for example in relation to infection control and nutrition. We saw the results of medication and care plan audits. Monthly audits of the medication administration records (MAR) were undertaken by one of the nurses, with whom we spoke. The same nurse undertook care plan audits monthly, sampling four sets of records. The audits showed that, where issues were identified, an action plan was produced. Matters were followed up in team meetings and through memos. The minutes of meeting showed this to be the case.

We saw that the results of audits were made available to the company electronically through the secure shared drive, where they were monitored by the quality and improvement manager.

We found that the provider made sure that people using the service were not harmed as a result of unsafe care by having in place a system to analyse incidents, establish what caused them and change practice as appropriate. Information was saved on the shared drive, and we saw there was feedback and follow up. For example, we looked at an incident where there had been a drug error. A notification went to The Brendoncare Foundation, where they were reviewed by a risk panel, and subsequent actions were detailed on the electronic system.

The registered manager undertook unannounced checks of the unit at night, and we saw a report following the last check undertaken in November, when all was found to be satisfactory.

There was a system of meetings in place, for nurses and carers. We saw minutes from the meetings, and these showed that a range of practice issues were discussed, and that issues were followed through. Staff told us they could raise matters for discussion at meetings, and the minutes seen reflected this.

This demonstrated that the provider had in place appropriate systems for gathering, recording and evaluating information about the quality and safety of care and support the service provided.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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