Inspection Report

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

The Raphael Medical Centre

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Hildenborough, Tonbridge, TN11 9LE

Tel: 01732833924

Date of Inspection: 22 March 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Raphael Medical Centre Limited
Registered Managers	Mr. Taneshwar Lallah Bhugobaun Dr. Gerhard Florschutz
Overview of the service	The Raphael Medical Centre provides care and treatment for up to 50 people with an acquired brain injury. The service is divided into three areas: the main unit, Tobias House for people in reduced states of consciousness, and the Special Care Unit for people with a mental illness in addition to an acquired brain injury.
Type of services	Long term conditions services Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 22 March 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with other authorities.

What people told us and what we found

People using the service had their capacity to consent assessed. Where they were able to make decisions for themselves, people had signed their consent to treatment. We saw that people were able to make choices and refuse care if they wished. Where people were not always able to make decisions for themselves, we saw that this had been discussed with relatives where possible, and the correct procedures were followed to ensure that people were cared for in their 'best interest' and their rights were protected under the legislation such as the Mental Capacity Act.

People had their needs assessed, and care plans and therapy timetables developed and implemented. There was a seven day a week therapy programme. Most of the people we spoke with, or their relatives, were positive about the service. One relative told us that "on the whole" they were "very happy with the care". Another relative told us it was an "amazing place", and others that the service was "brilliant, fantastic!"

We found that there were processes in place for the management and handling of medication. There were sufficient numbers of staff employed.

We saw that there was a process in place for managing complaints. People or their relatives that we spoke with told us that they felt able to raise concerns, and that these were usually addressed. Some people told us they had had problems, but these had been resolved.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

People using the service had their capacity to consent assessed. The manager told us that everyone in the service had had a mental capacity assessment, but no one was subject to Deprivation of Liberty Safeguards (DoLS) (a formal process that protects people's interests even if their liberty is restricted) at the time of our inspection. Staff told us that people may have the capacity to make some decisions about their daily lives but not others. They told us that different members of the team assessed people's capacity, depending on what the decision was about. Staff said that if a decision, or the assessment of the person's capacity to make it, was complex then a consultant psychiatrist or psychologist may assess the person.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We reviewed a sample of care records from different areas of the service. These stated that a person was presumed to have capacity until they had been formally assessed. The records we reviewed showed that some people were deemed to have capacity to consent to some areas of their treatment, and not to others. The records included assessments of people's capacity and completion of deprivation of liberty checklist and best interest protocols. We saw that on some occasions this had been discussed with the person's family and the social services or NHS department that was funding their care. Staff told us that most people did not have capacity to consent and the region-wide Kent and Medway best interests decision making tool was used for these discussions with families and advocates. We saw evidence of the use of the tool, and that in some of the records this had been updated and reviewed to reflect the person's changing support needs. Some of the care records were explicit that a person had fluctuating capacity, and identified areas where they were usually able to choose whether to accept or refuse to participate. The provider may find is useful to note that we saw that some of the consent forms had been signed by a person, who had been assessed as not having capacity to make such decisions.

A social worker had initially been employed in the Special Care Unit, but now worked across the whole service. Their role included accessing Independent Mental Health Advocate (IMHA) and Independent Mental Capacity Advocate (IMCA) for people. These were statutory advocates for people who were detained under the Mental Health Act, or who lacked capacity. We saw that a person had had a meeting with their IMCA on the day of our inspection.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We saw that the service had a general consent to treatment form, and additional consent forms for specific therapies or other aspects of the service, such as sharing information with other healthcare professionals. The sample of care records we looked at included completed consent forms, and/or best interest documentation. We saw that people had signed a consent form to say they agreed to their treatment, and also to having their photograph taken for the records. One of the staff said that if a person was able to consent then they would go through the form with them. Staff told us that if a person could not consent then their treatment plan was discussed with their family members and care was provided in their best interests. Staff said that a mixture of professionals discussed consent with the person and their families, which depended on the treatment being provided.

In addition to therapies such as physiotherapy, occupational therapy, and art therapy; the service used therapies that followed the "anthroposophical" approach. For example, the service had a "eurythmy" therapy room, which we were told was a form of movement therapy to support people with their gait, or how they walked. The service also used specific oils and ointments to rub into the skin, or to bathe in. Staff told us that there was some research into the therapies, but acknowledged that the evidence base was limited. The manager told us that they explained to people and their relatives what the aims of the therapies were, and what they believed were the expected benefits and any side effects. This was confirmed by one of the relatives we spoke with who said they felt they were kept involved with the proposed treatments and topical therapies administered at the centre, and they were able to discuss them with the team if they were unsure about anything. A member of staff said they respected people's wishes, and gave an example where a person had refused embrocation therapy (rubbing oils into the skin) because they didn't want to be touched.

The service had processes in place for ensuring people who were detained under the Mental Health Act (MHA) had their rights upheld. The service was registered to admit people under the MHA, and there were processes in place to administer this. There was no one detained under the MHA at the time of our inspection. Staff told us that they had had two people admitted who were detained under the MHA, but they had been quickly discharged from it. The manager told us that they had access to an Independent Mental Health Advocate (IMHA), and when detained people had been admitted the IMHA had been contacted straightaway. Staff told us they were working with one of their MHA managers to ensure they had all the necessary provisions in place and the paperwork was up to standard. We saw documentation of this, and evidence that the necessary checks had been carried out by the MHA administrator who had experience of this role in another mental health service.

Managers told us that service's policy is that all people using the service were to be resuscitated in the event of a medical emergency, such as a cardiac arrest. They said that if someone did not wish to be resuscitated this would be discussed with them, but this would be an exceptional circumstance. The staff we spoke with confirmed this, and said

that they had recently had two occasions where a person had been transferred form hospital with a do not attempt resuscitation (DNAR) form. They said they would not follow the forms, as it did not appear to have included consultation with the person it was about. Staff said they would not follow this, unless it had been discussed and confirmed within the service first.

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

One relative told us that "on the whole" they were "very happy with the care". Another relative told us it was an "amazing place", and others that the service was "brilliant, fantastic!"

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The care records showed that people had had a pre-assessment before they were admitted to the service. Following admission, numerous assessments were carried out which included medical and cognitive assessments, mobility and balance, and assessments by the doctor, physiotherapist, occupational and art therapists. Risks assessments were completed which included moving and handling, and related to specific activities such as swimming in the hydro pool. Staff told us that people had a multi-professional review meeting shortly after admission, and from this care and therapy plans were developed. This was supported by the sample of care records we looked at. They included a therapy timetable, and documented when people had attended or refused therapy sessions or outings.

The care staff we spoke with were aware of people's care plans and risk assessments. Staff told us that they read the care plans to determine people's needs, and made daily records of people's care. We saw that these were completed by nursing and care staff, and the therapists involved, and included physical observations, records of food and movement, care provided, and response to therapy groups attended.

The Special Care Unit records showed that people's care had been reviewed at least once a month by the psychiatrist, and risk and ligature assessments had been carried out. We saw that where a person's needs had changed, this had been identified and there had been discussion about the suitability of them remaining at this service.

We saw that samples of care records were audited. The provider may find it useful to note that there were some gaps that highlighted areas to be addressed. However, as different files were audited each month it was not clear that these had been followed up.

The staff we spoke with were positive about the care provided by the service.

Staff told us that there were meetings each evening which most staff attended to feedback about people using the service, review progress and set new goals. We were told that all the people using the service had a review meeting every two months to which relatives were invited. A visitor confirmed this, and said that the family felt involved in their relative's care and were "comfortable in raising issues of concern." They said that once an issue was raised, things usually improve afterwards.

The service employed a range of therapists that provided a therapy programme seven days a week. This included physiotherapists, occupational therapists, art, and music therapists. A speech and language therapist and dietician also provided regular input into the service. They provided a mixture of group and individual sessions. Staff told us that people using the service had a timetable, which for most people included two or three 30-minute slots with a therapist each day. This was confirmed by the sample of records we looked at. The physiotherapists we spoke with told us that in addition to providing direct care to people, they provided training and monitored staff regarding the correct moving and handling, and positioning of people with reduced and limited mobility and consciousness. They also made and adjusted splints for people.

Staff told us that the general physician's role was to look after people's general physical healthcare needs, as people with neurological injuries were susceptible to other healthcare issues such as being at risk of developing chest problems. The doctor also liaised with acquired brain injury and hospital services in the NHS. The doctor told us he aimed to see all people using the service at least once a week, and this was supported by the sample of care records we looked at.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. One staff member we spoke with told us that they had a good record for preventing pressure sores and contractures (permanent shortening and tightening of muscles). Staff told us that there were no people with pressure sores at the current time. One staff member attributed this to the fact that people had therapy and were mobilised regularly. They said they didn't use air mattresses all the time, as although they were commonly used to relieve pressure areas, they could lead to contractures with the people using this service. Staff told us that they tried to move or position people who weren't mobile every two hours, and used oils to support their skin integrity. One of the visitors we spoke with told us that their relative had not had any pressure sores for a long time, and were impressed with how the service had managed this.

There were arrangements in place to deal with foreseeable emergencies.
Staff told us that rehabilitation workers were trained in basic life support, qualified nurses in immediate life support, and the house physician in advanced life support. This was supported by a sample of training records. The doctor told us that in the event of a medical emergency their role would be to keep the person alive until an ambulance arrived and the person went to hospital.

A doctor provided a cancer day service at the centre for one day each week. We did not review this part of the service.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Medicines were prescribed and given to people appropriately. We saw that people's care, which included medication, was regularly reviewed by the service's doctor. The sample of medication administration records (MAR charts) we saw were completed correctly.

Medication was monitored in the service. The manager told us that medication audits were routinely carried out. We saw the most recent medication audit from March 2013. This included a review of 51 out of 53 MAR charts, and showed that 98% had been completed correctly. The audit included the action taken to address any errors. Staff told us that night staff carried out a check of MAR charts and counted medication twice a week. They said it was unusual for there to be errors, but when this had occurred it had been reported and investigated, and action taken. These actions included staff training and additional checks.

Appropriate arrangements were in place in relation to obtaining, storing and disposing of medicine. We saw that the service had a contract with a community pharmacy for the supply of medication. Staff demonstrated the process for ordering and topping up supplies of medication. This included recording medication when it came into and went out of the unit. We saw that medication was stored securely in the separate areas of the service. We saw that temperatures of medication rooms and fridges were monitored, and were within the recommended limits.

There were processes in place for the safe and secure handling of controlled drugs. We saw that the service had secure facilities for the storage of controlled drugs. The sample of records we looked at showed that they were recorded appropriately. The service had an accountable officer for controlled drugs (CDAO), in accordance with The Controlled Drugs (Supervision of Management and Use) Regulations 2013. As the CDAO is a qualified nurse working in the unit, the provider may find it useful to note that the regulations state that the CDAO should not be routinely involved in the supply and administration of controlled drugs.

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

There were enough qualified, skilled and experienced staff to meet people's needs. We saw that the service employed and contracted a range of healthcare professionals. Registered general nurses (RGN) were employed in the main unit and Tobias House, and registered mental health nurses (RMN) in the Special Care Unit. Rehabilitation workers or healthcare assistants, and a team of therapy staff worked throughout the service.

The staff we spoke with said there were usually enough staff working within the service to meet people's needs. The stated staffing levels were consistent with the staffing rotas we looked at. Staff told us that agency staff were not used on the main unit or in Tobias House, and if they were short staffed one of their own staff, or a bank staff would cover it. There was an RMN vacancy in the Special Care Unit which was being covered by agency staff.

The people we spoke with or their relatives were mostly positive about the staff. The provider may find it useful to note that a relative told us that there were "lovely staff", but that some of them spoke limited English which made it difficult to communicate. The manager acknowledged that this was an issue with some staff, and the service was trying to source English courses at a local college.

Another visitor told us that their relative had had a number of different carers over a short period of time because of the turnover of staff. They felt that their relative's needs were still met, for example they felt they were "very good" at going with them to hospital appointments, but sometimes the new staff needed reminders about elements of their relative's daily care.

The service employed a full time GP and a consultant neurologist, and other medical staff attended regular sessions which included a rehabilitation specialist and a consultant psychiatrist. The manager told us that other specialist staff were brought into the service on an "as necessary" basis.

The service employed a range of therapists that provided a therapy programme seven days a week. This included physiotherapists, occupational therapists, art, and music therapists. A speech and language therapist and dietician also provided regular input into

the service. The manager told us there were currently no vacancies for therapists. The staff we spoke with said there had been a physiotherapy vacancy, but this post had now been recruited to. The service also employed a social worker who was based in the Special Care Unit, and provided advice and support with regards to people's rights and social support.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The service had processes in place for managing complaints. Raphael Medical Centre is a member of the Independent Sector Complaints Adjudication Service (ISCAS) and adopts their Code of Practice regarding the handling of complaints.

We asked for and received a summary of complaints people had made and the provider's response. People's complaints were fully investigated and resolved, where possible, to their satisfaction. The manager told us that the service had not received many formal complaints. This was confirmed by the complaints information we saw. The complaints folder showed that a written complaint had been received from a relative, investigated by the service, and the outcome recorded. This included the action taken and the feedback given to the relative.

People had their comments and complaints listened to and acted on. A relative we spoke with told us they had raised a number of issues on an informal basis. They said this had achieved satisfactory outcomes, so they hadn't needed to take any further action. They said they felt able to raise issues directly with the provider or senior managers within the service, but knew how to raise a formal complaint in writing if they ever needed to do so. We saw that there was a form to be used by staff to address informal complaints and record the outcome. However, the provider may find it useful to note that we did not see evidence that these had been used, or that day to day complaints had been recorded and resolved.

People were made aware of the complaints system. We saw that the service had a "Statement of Purpose" which explained the complaints procedure to be followed if anyone wished to raise either a verbal or written complaint. It set out the expected timeframe for a written response from managers and included how verbal complaints should be made and escalated if necessary. Staff told us that there was a copy of this in each of the bedrooms. We saw a limited number of bedrooms, so were unable to confirm if this was the case. However, we saw that there was information about how to complain on display in public areas of the home.

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.

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