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: 05 November 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
Meeting nutritional needs	✓ Met this standard
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✓ 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

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 5 November 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 reviewed information given to us by the provider.

What people told us and what we found

When we visited there were sixteen people using the service. Fourteen of these were receiving an intermediate care service and two were having a respite stay. Overall, people were positive about their care and treatment and the skills and knowledge of the staff. People told us 'its excellent', 'I think this place is meeting standards' and 'staff are very caring'. We saw examples of care being delivered sensitively and in a friendly and person centred manner. People felt involved in decisions relating to their care and treatment. We found the service placed a strong emphasis on the central place of nutrition to the recovery process and people were mostly protected against the risk of inadequate nutrient or hydration.

The service had suitable arrangements for monitoring the quality of care so that people were protected against the risks of inappropriate or unsafe care and treatment. We observed that the nature of the unit presented staff with a number of challenges in relation to ensuring effective transfer of care processes from the acute hospitals and this had an impact on the continuity of care for some people using the service. We found the provider had not taken appropriate steps to ensure that there were a sufficient number of suitably qualified and experienced staff available to meet people's needs at all times and improvements are needed.

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

What we have told the provider to do

We have asked the provider to send us a report by 02 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement

powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We saw evidence that consent to an intermediate care placement had been obtained from people who were referred to the service. Where people were able to, they had signed consent forms as part of this transfer process. These indicated that people understood the care the service was providing and were happy to participate in the agreed goals of their rehabilitation.

Staff we spoke with were aware of the need to seek the consent of people using the service before they provided care, support and treatment. For example, one staff member told us she always asked the person if it was alright to begin supporting them with their care. Another staff member said she always 'respected peoples wishes' should they decide to decline care. They added they would 'encourage, explain and communicate clearly' to try and achieve consent so that the person's needs could be met and their wellbeing maintained. All the staff we spoke to had completed training in mental capacity.

On the day of our visit we were told by a member of staff that there was a person using the service who lacked capacity to give consent to their day to day care and support on the unit. The provider may wish to note that when we reviewed this persons care plan we were not able to clearly see that the provider had taken all the necessary steps to ensure that there were robust care plans in place to facilitate ongoing assessment of the person's capacity and cognitive state where this might impact on the delivery of their day to day care on the unit.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Senior staff told us that whilst they did not routinely carry out pre-admission assessments for those people coming to the intermediate care unit, they did take steps to actively screen all referrals. They also told us they tried to ensure that pre-admission information provided by hospitals was accurate and detailed, and that the person would benefit from using the service. However, the provider may find it useful to note that at times individual's needs had not been clearly established at the point of referral to the service. Despite the units efforts to ensure that information about a person's needs was accurate at the point of transfer, there were instances where those admitted to the unit were not sufficiently medically stable to benefit from a rehabilitation programme or information about their needs was incorrect or inaccurate.

We were shown documentation which indicated that in October 2013 the unit had made six emergency admissions back to hospital. Whilst this meant the service recognised when it was not able to safely meet an individual's needs, the outcome for people using the service was that they did not always experience continuity in their care and treatment. To address these concerns, the manager told us they were being pro-active in seeking a range of measures which would develop links with hospitals and strengthen the transfer of care process. These measures included more regular meetings staff responsible for discharge planning at the acute hospitals.

Following arrival on the unit, people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at care records for three people and spoke with five people using the service. We saw that staff undertook an assessment of people's needs promptly upon admission to the unit. Staff used this information to devise a variety of care plans and risk assessments which we found were regularly reviewed and considered the individual's circumstances and their immediate and long term needs.

There was evidence that people using the service were happy with their care. One person told us 'staff are very kind'. Another person commented 'there is nothing they could have done better; you are waited on hand and foot'. We spoke with one relative who told us his wife had only been on the unit for five days but that the physiotherapist had already visited

and drawn up an exercise regime tailored specifically to the goals she needed to achieve to be able to return home safely. People we spoke with said staff understood their needs and provided support in line with their care plans. We spoke with three staff, all of whom told us they felt there was sufficient information in people's care plans to ensure they were able to deliver care effectively.

Staff told us the daily handover meeting and the handover sheets were effective tools in communicating information about new admissions and changes in the needs of people using the service. We observed a handover meeting during which there was a comprehensive discussion of people's needs, level of function, risks and discharge needs. This helped to ensure people received care from people familiar with their needs.

We looked at the arrangements the unit had made to meet peoples' social and emotional needs. We saw that on four days a week, the unit ran an activities programme. Twice a week this involved rehabilitation assistants running armchair exercise classes. On the other days volunteers provided opportunities for people to join in games such as cards and scrabble. We spoke with one of the volunteers at the service who told us she enjoyed her role. She said she felt the patients were always happy' and that she enjoyed 'talking with the residents who liked to have a chat'.

People were also able to access the restaurant and activities that were taking place in the extra care accommodation attached to the unit. The provider advised the service had just employed an activities co-ordinator to further develop the activities programme so that they were able to maximise opportunities to meet peoples' social and emotional needs.

There were arrangements in place to deal with foreseeable emergencies. For example, staff told us the service had regular fire drills and had previously completed a full practice evacuation. We were shown a 'location and mobility' fire plan. This provided information about which rooms were occupied by people and their moving and handling needs. This was updated every 24 hours by the night staff. These arrangements mitigated the risks to people using the service in the event of there being a fire or other emergency affecting the safety of the premises.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

During the inspection we saw evidence that the unit placed a strong emphasis on the importance of good nutrition in promoting recovery throughout the rehabilitation process. Each person's bedroom had a nutrition folder which contained information for people using the service about how to maintain a balanced diet, adequate hydration and how to achieve this through making healthy eating choices. For example, there was information about foods choices that could aid wound healing and strengthening of bones and muscles.

People using the service told us the food was tasty and provided in sufficient quantities and they were offered a choice of menu including healthy alternatives. We looked at a sample of menus for the lunch time meal and saw people were offered a good level of choice. The home had identified which meals choices were appropriate for people with specialised diets.

The provider had taken appropriate steps to identify those people who may be at risk of poor nutrition. We found the Malnutrition Universal Screening Tool (MUST) had been completed in the sample of records we looked at. (MUST is a five step screening tool to identify adults who are at risk of under-nutrition or obesity). Staff had also liaised with clinicians and other professionals such as speech and language therapists to inform the nutrition care plans they had put in place to manage identified risks such as swallowing difficulties. We observed that staff followed guidance contained within people's nutritional care plans and this ensured they received food in line with their individual dietary needs.

People were encouraged to take their main meals in the dining room as this provided an additional opportunity for staff to encourage people using the service to practice their mobility and work toward achieving their rehabilitation goals. We were told meal times were 'protected' and visitors discouraged so that people could eat their meals without disruption. This allowed staff to focus on providing assistance to those people unable to eat independently. Two members of staff we spoke with told us they had sufficient time to support people at meal times. A relative confirmed that his wife always received the help she required with cutting up her food so she could then eat independently.

The provider may find it useful to note that we found some records used to monitor people's nutritional needs had either not been fully completed or contained similar information that was recorded in a number of places. For example, we saw that for one

person no fluids had been recorded between 8am and 4pm on 1 November 2013 and on 3 November 2013 there were no entries of fluids given between 9am and 9pm. In another person's care records we noted staff were using three different types of record to document similar information about the person's nutritional needs. This meant staff might not readily have access to information that would help them reach judgements about a person's nutritional wellbeing.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The manager told us the current staffing levels for both the rehabilitation and the respite beds were two nurses and three or four care workers in the morning from 8am to 2pm, two nurses and two care workers from 2pm to 8pm, and one nurse and one care worker at night. The unit was also usually supported by a team of volunteers who provided assistance throughout the day with tasks such as serving drinks and social activities. Overseeing the unit there was a nurse manager who was supported by the registered manager.

In addition to nurses and care workers, the staffing levels for those receiving rehabilitation were enhanced by a clinical and therapy team which consisted of a part time physiotherapist, a part time occupational therapist and two part time therapy assistants. An elderly care consultant visited weekly to undertake a ward round and a medical review of those people receiving the intermediate care service. A local GP surgery provided five hours medical care each week, but we were told they would attend outside of these hours if needed. The clinical and therapy staff work for Southern Health NHS foundation Trust and are commissioned by the South West Hampshire Clinical Commissioning Group (CCG) to provide the therapy service at Knightwood. (A clinical commissioning group is an NHS organisation set up to organise and deliver NHS services in a local area).

The manager told us they tried to ensure that they planned admissions around their staffing levels to provide an effective and safe service. They also told us that they used floating and bank staff to increase staffing levels in response to increased levels of dependency of people using the service. This demonstrated that the unit was committed to providing an accountable and responsive service. However we found that three times in the last two months the service had needed to raise an incident form due to concerns about staffing levels when agency staff had not arrived for their planned shifts.

On the day of the inspection we had concerns that staffing levels meant that people using the service were potentially at risk of not having their needs met in a responsive manner. For example, we observed a person in the corridor seeking assistance from staff. When

staff attended they asked him why he had not pressed his bell – he replied 'I have been doing but nobody came'. We spoke to another person who told us her only complaint was that 'when I press the bell, staff don't come; I think they are short staffed'.

These concerns were repeated by another person who said that they had 'pressed their bell several times this morning and no one had come. They told us they had been concerned they were going to have an 'accident' but said 'eventually someone came'. Concerns about staffing levels were expressed by a further two people we spoke with. For example, we were told that when a volunteer was not available, they did not always get their between meals hot drinks. Whilst one person said this did not happen often, they explained they did not like to ask staff about this as they 'always seemed so busy'.

One care worker told us that 'sometimes we could do with extra' (staff). This was confirmed by a second member of staff who said 'teamwork was good on the unit…but at times there were not enough staff and on certain days you did feel the need to rush.' This member of staff added people did have to ring their bells a long time but they did always try and go and explain that they would be with them soon. They said they 'did not feel that anyone was at risk of harm, except maybe emotionally if it meant that they were worried that they might have an accident'.

We also had concerns that on one recent occasion, the night care team consisted entirely of staff from a care agency. Whilst the agency nurse ha completed previous shifts within the unit, we were concerned that this could potentially increase the risk to people as there was not enough staff familiar with their needs available to support them. The provider told us they always ensured that agency staff had a comprehensive handover at the start of their shift. They also said they provided a care worker from the extra care unit to work alongside them who would have a good understanding of the systems in place within the service.

We looked at a sample of service user feedback from April 2013 about the responsiveness of staff when assistance was needed. Some people were positive about the time taken for staff to respond, others felt this could be improved. We spoke with the manager about this and they advised that they would undertake an audit of the call bell monitoring system to make sure that people using the service were receiving prompt responses to their requests for help.

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.

Reasons for our judgement

The provider had systems in place to assess and monitor the quality of care and people who use the service were asked their views about their care and treatment. Most people said in feedback that they were happy about the amount of involvement they had in decisions around their care and treatment. Positive comments had been made such as 'staff were polite and helpful'.

The provider had taken measures to seek the views of people using the service about the quality of food. Where feedback had indicated that improvements were required, the provider was taking measures to address this. For example, it had been identified that people who required a pureed diet were not always receiving a sufficient variety of foods so the service developed a system for freezing a range of meal choices in ice cubes trays. This meant that a wider selection of foods was available at all times for people despite their requirement for a special diet.

The manager told us the service had not received any complaints since the last inspection. There was information about to how make complaints or comments in each person's bedroom which was clear and accessible. Two people we spoke to said they would feel comfortable talking with the manager should they have a concern and they felt this would be dealt with fairly.

We looked at a sample of incident and accident forms to see whether the service learned from 'near misses'. We found the provider had reviewed these to make sure people using the service were protected from risks associated with unsafe care, treatment and support. For example, we saw an incident form relating to a medication error had been completed. The manager had investigated the incident to establish what had caused the problem and had subsequently undertaken actions to prevent similar incidents occurring in the future. These included re-iterating roles and responsibilities to nursing staff and providing refresher training in medication administration.

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.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not made sure that there were always sufficient numbers of appropriate staff with the right knowledge and skills to meet the needs of people who used the service. Regulation 22

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 02 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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