Care Quality Commission

Pear Tree House Rehabilitation Limited

Peartree House

Inspection report

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Ratings

Overall rating for this service	Good ●

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 February 2018. It was unannounced.

Peartree House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and looked at both during this inspection.

Peartree House specialises in the rehabilitation of people recovering from an acquired brain injury. It can accommodate up to 46 people in an adapted listed building with annexe accommodation for people with greater independence. At the time of the inspection there were 35 people living in the home and annexe with a further two people supported in their own homes.

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

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to store and administer medicines safely, and to manage the risk of infection. There was a culture that encouraged learning from experience.

People's assessments, rehabilitation and care plans were based on appropriate professional standards and guidance. Staff received appropriate training and supervision to maintain and develop their skills and knowledge to support people according to their needs. Staff were aware of and put into practice the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses. The provider had adapted the home to accommodate people recovering from brain injury.

Care workers had developed caring relationships with people they supported. People were encouraged and supported to take part in decisions about their care and support and their views were listened to. Staff actively respected people's independence, privacy, and dignity.

Care and support were based on assessments and plans which took into account people's abilities, needs and preferences. People were able to take part in leisure activities which reflected their interests. People were kept aware of the provider's complaints procedure, and the provider dealt with complaints in a professional manner.

The home had a warm, welcoming atmosphere. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable for work in a care setting.

Processes were in place for the management of medicines, the control of infection, and for learning from incidents.

Is the service effective?

Good ●

The service was effective.

Staff were supported by training and supervision to care for people according to their needs. People's care was planned according to professional standards and guidance.

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

The service had been adapted to take into account the needs of people with brain injury.

Is the service caring?

Good ●

The service was caring.

People had developed caring relationships with their care workers and other staff.

People were supported to participate in decisions affecting their care and support.

People's independence, privacy and dignity were promoted and respected.

Is the service responsive?

Good ●

The service was responsive.

People's care and support met their needs and took into account their preferences.

There was a complaints procedure in place, and complaints were dealt with professionally.

Is the service well-led?

Good ●

The service was well led.

There were effective management systems and processes to monitor, assess and improve the quality of service provided.

There was a friendly, empowering atmosphere in which people were treated as individuals and could speak up about their care and support. People and their families were engaged by the provider.

Peartree House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a routine, unannounced comprehensive inspection which took place on 1 and 2 February 2018.

The inspection team consisted of an inspector, inspection manager and Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with seven people who lived at Peartree House, and five visiting family members. We observed care and support people received in the shared area of the home, including part of a medicines round.

We spoke with the registered manager, the owners, and other members of staff, including three support workers, two registered nurses, the matron and their deputy, occupational therapists, physiotherapists, and a speech and language therapist employed by the service. We spoke with members of the administration and catering teams, and a visiting healthcare professional.

We looked at the care plans and associated records of five people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, the provider's improvement action plan, quality assurance survey returns and reports, training and supervision records, medicine administration records, mental capacity assessments, Deprivation of Liberty applications and authorisations, staff rotas, and recruitment records for six staff members.

Good ●

Is the service safe?

Our findings

People told us the provider took steps to keep them safe and manage risks to their safety and wellbeing. One person said, "There is always someone with me when I use the kitchen." Other people said staff always came quickly if they needed help, and staff kept a check that they ate and drank enough.

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. All staff received training in safeguarding adults, and for care staff this was supplemented by mentoring by nursing staff. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the registered manager. Leaflets giving advice on how people could keep themselves safe, and how to report any concerns, were freely available to people near the entrance to the home.

The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse. Staff were aware of and confident they could use the provider's whistle blowing policy. Staff knew about techniques to help them record and report concerns, such as the use of body maps to show unexplained bruising. If concerns were raised, senior staff carried out an investigation to identify any lessons to learn, whether or not the concern was genuine. Where appropriate the provider notified other agencies about concerns, and cooperated with the local authority when they were requested to undertake enquiries into concerns.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with falls, moving and positioning, mobility, skin health, and the use of wheelchair seat belts and bed rails. Guidance for staff about managing risks in ways that did not restrict people's freedoms was carried forward into people's care plans.

Staff told us care plans contained the information they needed to make sure they kept people safe while supporting them. There were personal emergency evacuation plans which showed staff how to support people in the event of fire or similar emergency. These were detailed and individual to the person.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff, and staff told us their workload was manageable. The registered manager told us staffing levels were based on people's needs and dependency. We saw staff were able to carry out their duties in a calm, professional manner.

The provider had recently carried out a study to verify that there were enough staff on duty at all times of day. This had led to some changes to the number of staff on duty at night. There had also been adjustments to staffing levels in response to call bell response times. Staff in one area of the home raised concerns about the staffing levels in the annexe where care staff were also responsible for cooking meals. We passed these on to the registered manager who undertook to review them.

In the event of absences the provider had a bank of employed staff and a long term relationship with an agency to make sure there were always enough staff deployed. The registered manager worked with the agency management to identify staff with the right skills. New agency staff received two days shadowing with employed staff before they were deployed on their own. We saw people knew the agency staff and called them by their names.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. There were also checks that nurses' registration was up to date, and that overseas staff had the right to work in the UK. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people.

Medicines were stored and handled safely. Medicines training and competency checks were in place for staff. We observed part of a medicines round. Nurses observed suitable hygiene practices. They encouraged people to take their medicines, explaining what they were for. They were aware of how people liked to take different medicines and offered them accordingly. They made sure the person had swallowed their medicine before moving on to the next person.

People's medicine administration records contained the necessary information. Records were accurate and up to date. Suitable procedures were in place where people were prescribed medicines to take "as required". There was a system of peer checking whereby the medicines records were checked by a colleague. People received their medicines as prescribed and according to their needs and preferences.

Arrangements were in place to manage risks associated with infections and food hygiene. There was appropriate training for staff, and one staff member had been identified as the lead for infection prevention and control. They produced an annual statement for the provider, which was in line with government guidance. This was backed up by a monthly infection control checklist used to make sure the provider's policies and procedures were followed. We found the home to be clean and free of odours.

The provider encouraged staff to be open and transparent if things went wrong. Staff told us there was a "no blame" culture which promoted the sharing of information. The provider had an "opportunity to learn" form which could be used by staff to record when things could have been done better, such as a medicines error. Senior staff or the registered manager carried out an analysis of accidents, incidents and near misses to identify any trends or patterns. Where appropriate learning was identified, it was communicated to staff, for instance by staff memos.

Good ●

Is the service effective?

Our findings

People and their families gave us examples of positive outcomes for people. One person said, "[Staff are] very focused on bringing your confidence back, and keen to bring you back to the lifestyle you are used to as an independent person." Another person told us themselves that when they came to the service they could not speak at all. Speaking of the staff, they said, "The most important asset they have here is the people, and the people are brilliant." A visitor said their family member was a "completely different person" from when they came to live at Peartree House. Another visitor told us, "After the first week I knew [Name] was in the right place. I go home with the feeling [Name] is in good hands."

People's rehabilitation, care and support were based on assessments which took into account the knowledge and expertise of in-house professional staff. These included physiotherapists, occupational therapists, a speech and language therapist and psychologist. They also took into account input from people's families and the discharging hospital. Professional staff kept their knowledge up to date using peer networks and continuing professional development. People could be confident their care and treatment was planned to be in line with current standards and designed to achieve positive outcomes.

People's assessments were used to draft a proposed rehabilitation plan with input from each of the professional areas. These included timescales, goals and estimates of the hours of support needed from each area. The in-house professionals also contributed to care plan sections which included guidance for care staff on how to support people with their day to day needs, for instance communication care plans were drafted by the speech and language therapist.

Care plans were detailed and individual to the person, and included explanations and rationale for the guidance included. Examples of areas covered by these care plans included nutrition, skin health, and moving and positioning. Where appropriate, photographs were used, for instance to illustrate physical exercises. There was clear guidance in each area, and plans were reviewed with the person and their family after four to six weeks and regularly thereafter.

The provider took into account a range of standards and guidance available including a hospital charity specialising in rehabilitation from acquired brain injury, recognised standards in neuro physiotherapy, and published guidance on stroke recovery. Where appropriate people's care plans included standard tools to assess the person's risks, for example the risk of acquiring a pressure injury.

Staff had the right knowledge and skills to support people effectively. Professionally qualified staff were able to maintain their qualification and registration with time being made available for reflective practice, career progression and mandatory training. There were opportunities for staff to discuss issues of practice and share learning in peer to peer supervisions and multi-disciplinary team meetings. Staff were able to investigate and research new developments in their area of expertise and trial new equipment. The provider had also piloted music therapy and swimming therapy where these were judged appropriate to people's needs. A member of staff said, "Ideas are never refused."

The provider had a programme of mandatory training, supervision and appraisal for all staff and systems were in place to track when courses were due for renewal. Staff felt supported by the supervision and appraisal programme and had the opportunity to raise training and development needs. There was knowledge sharing between staff with occasional group reflective sessions and more formal training given by the nursing staff, for instance in sepsis and the use of observations.

People had access to sufficient food and drink throughout the day. People were very complimentary about the catering. One person said the food was "superb", the meals were "stunning" and staff "had a passion for food". Another person said, "The food is really good, and they offer quite a selection and always lots of vegetables." A visiting family member said, "The food is really good, big choice."

Kitchen staff were aware of people's preferences and nutritional needs based on feedback from care staff. They catered for a vegetarian, for people with diabetes, for people who needed a weight reducing diet, and for people with swallowing difficulties who need either a pureed or chopped diet.
Pureed meals were presented in a way that made them appetising and encouraged the person to eat.

Other professional staff members were involved in making sure people received a diet which met their needs. If people required an individual nutrition care plan, this was developed by the speech and language therapist. Physiotherapists observed people at meal times to advise the best posture when eating and resting.

There was a strong emphasis on cooperation within the staff. One staff member described the multi-disciplinary team as "the focus of the service". At times the staff came together as a whole team to reflect on complex care issues, which enabled them to identify areas where their practice could be improved. Staff also liaised with professionals from the local NHS hospital, for instance around areas of skin health and nutrition. There had been a recent visit by a nurse specialising in learning disabilities. People's care, support and rehabilitation was founded on internal and external cooperation.

People's physical health care plans were developed by the in-house nursing staff. Records showed people had access to other healthcare services when necessary. These included referrals to people's GPs, dentist appointments and attendance at hospital outpatient services including breast screening and ultrasound scans. A visiting healthcare professional told us they found the service to be well organised and staff were "really good with patients". Staff contacted them appropriately, always had the information they needed and followed their advice and guidance.

The provider had made adaptations to the building to allow people to make use of specialist equipment on site to help their rehabilitation and recovery. There was a dedicated and equipped in-house physiotherapy room. Occupational therapy could take place in adapted kitchens, and in an outside shed and greenhouse. An enclosed garden had been adapted to make it more easily accessible to people who used a wheelchair. There was a recently refurbished shared lounge and entrance area which were spacious and accessible to wheelchair users. Areas of the original building were less spacious and accessible, but the provider had aspirations to develop some of those areas, which would be subject to listed building planning consent.

Staff were aware of the need to seek people's consent to any care, support and treatment. Where people were able to, records showed they consented to their care plans and individual treatments such as flu vaccinations.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the Act, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff showed an understanding of the Act and its associated code of practice. Records of capacity assessments showed the legal processes had been followed. Where people were assessed as lacking capacity for a particular decision, records showed that correct processes were followed to make a decision in the best interests of the person. Where a condition had been placed on an authorisation to deprive a person of their liberty, the provider had started discussions with their commissioning authority about how to fund the additional support needed to meet the condition.

Good ●

Is the service caring?

Our findings

The provider made sure people were supported and treated with dignity and respect, and were involved in their care. One person told us staff were "massively good at listening to thoughts and then explaining to me". Another person said, "The best thing here is the staff are fantastic. I consider them as friends, not staff." Visitors told us they could visit whenever they needed to and stay as long as they liked. One visitor said, "Care staff are very caring and engaged." Another family member told us, "Staff have fun and are on a level with the patients." All the interactions we saw between staff and people were positive and caring.

Staff had the skills needed to make sure people received compassionate care and to treat people as individuals. A visiting healthcare professional told us staff knew people really well. We saw and heard that staff were aware of people's interests and could have conversations about subjects relevant to the person as well as chatting informally when supporting people with their care.

Staff relationships with people were based on a "residents charter" which had been drawn up between staff and the people they supported. It included references to choice, privacy, participation, dignity, fulfilment, and individual rights. This showed people were listened to and could influence the service they received. Staff took account of people's communication abilities and were aware of techniques to help them understand. One staff member showed a person the clock as well as telling them the time. People could follow their own preferred routines and choose their own menus. Staff were aware of when people could be independent, and if offered support was declined, staff respected that decision.

The provider took into account people's skills and abilities, and involved people and their families in decisions about their care and the service they received. One person with IT skills acted as a consultant to the provider in decisions about IT projects. Records showed people and, where appropriate, their families, were involved in their care plan assessments, development, evaluation and reviews. Where people were approaching the end of their rehabilitation pathway, staff supported them with applications for support and housing in the community.

Staff were conscious of the impact on families of the sudden change in circumstances caused by acquired brain injury. People's families were involved in care planning and also supported by it. Occupational therapists and physiotherapists advised families on changes they could make to the person's home. There was a keyworker system which meant people and their families had a named point of contact on the staff they could contact with any questions, ideas or concerns. The provider arranged monthly meetings for family contacts, and also invited them to events, such as an afternoon tea. These provided opportunities for two way communication with family members.

The provider was aware of their responsibility to provide information in suitable formats for people with a disability or sensory impairment. Leaflets were available in the service providing information on advocacy, community service, safeguarding and the provider's complaints process. This could be provided in accessible formats such as large print, and easy-read using pictures. The provider also offered to provide information in the form of video and audio recordings.

The provider took steps to make sure staff respected people's independence, privacy and dignity.
There was a nominated staff dignity champion to act as a focal point for both staff and people. The provider had organised a dignity workshop, an event for families called "digni-tea", and included dignity in their monthly quality audits.

People and their families confirmed there was a focus on independence. Staff supported people to visit their families at home, and showed family members how to support people. They showed a person's family how to manage their tube feed, so they could support the person to achieve a greater degree of independence while they received their nutrition directly into their stomach through a tube because of swallowing difficulties. An annexe to the main house and ground floor flats in another building were available for people who had achieved a greater degree of independence.

People and their families told us their wishes and choices were respected, and staff took steps to preserve people's dignity. We saw staff knocking on people's doors and asking for permission to come in. Staff told us they explained in advance what they were going to do, offered choice and concentrated on making people "feel at home".

Good ●

Is the service responsive?

Our findings

People received assistance with their personal care, support and treatment that met their needs and took into account their preferences and wishes. The service was arranged to support people on a rehabilitation pathway and people who were likely to be resident for a longer period. Accommodation was available to reflect people's level of independence. Those who needed most support lived in the main house. The staffed annexe was available for people who were able to be more independent, and the service also supported two people in their own homes.

People confirmed that the service they received met their needs. One person said, "Whatever I ask for they adapt." Another person told us how staff supported them to make overnight visits home, and another described how they were supported to plan their move out of the home permanently. There were written testimonies from people's families and others involved in their care. One person's advocate had written, "It is a remarkable place and a real home for the residents. I am full of admiration for you and all your team." Another family member had written, "[Name] left Peartree a much happier person than when he first arrived."

People's care records contained daily notes by members of the multi-disciplinary team which showed the progress people made towards their rehabilitation goals and reflected the effectiveness of people's care and support. When people attained their agreed goals, they were involved in discussions about setting new goals, and these were recorded in their care plans.

Care plans included detailed information about the emotional impact of their brain injury and guidance for staff on how to deal with their changes in mood and behaviour. There was also information for staff about individual communication needs arising from people's injury. Some people supplemented their spoken communication with signs or pictures, and one person had the use of a computer tablet to help them express themselves.

Care plans contained information about people's life, family, previous employment, goals, dreams and hobbies. People received support to maintain contact with their family and friends. Other people were supported to take part in the community by visiting local shops, cafes and community groups, and taking buses into the centre of town. Other leisure activities available to people included entertainers and therapy animals which visited the home.

Staff made people aware of how to raise any concerns or complaints, although we saw that some people had to be reminded of how to do this. The provider's complaints policy was clearly displayed in a shared area of the home. There had been two minor complaints in the year before our visit. Both of these had been managed to the satisfaction of the person making the complaint. There was also a suggestions box for people to promote ideas about how to improve the service.

People were able raise any concerns or suggestions during their daily contact with staff, residents meetings and informal gatherings such as afternoon tea with visiting families. People and their families were confident the registered manager would deal effectively with any complaint, and were happy to raise minor concerns with staff members. People felt they would be listened to if they raised a concern.

One person's family member said any complaints were dealt with straight away. They gave an example of a problem they had mentioned to the registered manager who had dealt with it on the spot.

Good ●

Is the service well-led?

Our findings

There was a positive culture at the service, with effective team working, communications within the staff team and between staff and the people they supported. This meant people received care which was individual and focused on their personal plans and aspirations. A visitor described the atmosphere in the home as "friendly, open and transparent". The provider's vision was to become "the rehabilitation centre of choice". They were working towards formal approval by a nationwide charity dedicated to improving the experience of people with brain injuries.

Staff were positive about how the service was managed and the leadership of the registered manager and owners. Staff told us they felt empowered to share ideas, and that there was a "good, strong management team". One staff member said, "I feel part of the team. Communication is very good. I feel included. I can go to any other member of the staff team for advice and they will give it to me." There was a programme of workshops where staff members were encouraged to reflect on how they could apply the values of the service in the practical care and support people received. One of these had been on the subject of "Dignity for Peartree".

There was a clear and effective management system. Staff understood the organisation of the service and their own roles and responsibilities. They told us they received clear direction from the management team. One staff member said, "I know what my job is." There were regular staff meetings, nursing meetings and clinical governance meetings. Actions arising from these were tracked and records updated when completed.

Systems were in place to monitor and improve the quality of service people received. These included monthly internal audits of areas such as care plans, infection control, medicines and pressure injuries. At the time of our visit there were no pressure injuries recorded. An external quality consultant had been engaged to visit monthly and advise on areas for potential improvement. There were also regular informal visits by the owners to assist and advise the registered manager.

The registered manager was aware of their responsibilities in running a regulated service. They notified us of certain events that took place in the service as required by regulations. They were aware of the "duty of candour". This is a regulation which requires providers to inform and apologise to people or their families when certain incidents occur during their care. Information about the home's registration and the ratings from their previous inspection were clearly visible near the entrance to the home.

The provider engaged with people and their families through their regular involvement in people's care assessment, progress tracking and care plan reviews. There were also residents and family meetings where concerns could be raised, and less formal gatherings when families were invited into the home. People told us concerns raised at these meetings and events were followed up.

There were processes in place to make sure the service continued to improve. A member of staff said, "We learn from mistakes to encourage improvements." Another staff member said, "It is all about learning and going forward." Staff came together to reflect both when things went well and when things went less well. This meant practice found to be effective was reinforced and lessons were learned when things did not go well. If appropriate external partners, such as the clinical commissioning group, were included in these reflective sessions.

The registered manager had an ongoing improvement plan. As well as working towards external recognition and accreditation, this focused on the use of technology to improve people's experience, respecting people's dignity and the provision of more meaningful activities for people.

The service worked in partnership with a number of external agencies to maintain best practice in rehabilitation and social care. These included the local care home network, initiatives from the NHS Trust, and other trusts and charities specialising in acquired brain injury.