Care Quality Commission

Chilmington Homes Limited

Chilmington House

Inspection report

Armadale Court
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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

Overall summary

The inspection took place on 14 April 2015 and was unannounced. The service provides personal care support for up to seven people with a learning disability or who had needs within the autistic spectrum. Some people may have additional physical disabilities or sensory impairment. Care was being provided to six people at the time of the inspection.

The service was required to have a registered manager and one was in place. A registered manager is a person who has registered with the Care Quality Commission 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 service met people's needs effectively and staff knew the people and how they communicated their wishes and emotions very well. We saw that people had positive relationships with staff and trusted them. People's expressions and some verbal feedback indicated that people felt safe and well cared for.

Summary of findings

Staff were kind and patient and involved people in day-to-day decisions about their care as much as possible. People were encouraged and given time to make choices for themselves and staff checked with them before providing care support.

People's rights were safeguarded and each had the support of either family or local authority advocates. Feedback about the service from external professionals was very positive and no concerns had arisen regarding the care provided since the last inspection.

People had very good access to the local community and a wide range of activities supported by staff. The service had two adapted vehicles to ensure everyone could access the community.

People's moves into the service from elsewhere were managed very well at the right pace for the person's needs. Staff were well trained, effectively supported and were enthusiastic and motivated in their work.

People's health and dietary needs were met by staff and people could choose what they wanted to eat. The service managed people's medicines effectively on their behalf and in people's best interests.

The provider had a clear set of values and ethos for the service which staff understood and followed. The service was well managed and monitored by the management team and the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were sufficient, well trained and experienced staff to keep people safe and staff knew people's needs well.

Staff understood how to keep people safe and appropriate risk assessments had been completed to address potential risks.

People's medicines were managed safely on their behalf.

Good

Is the service effective?
The service was effective

Staff received an appropriate induction and training and received effective on-going support in their role. Staff understood how each person communicated their wishes and emotions.

Staff understood how to protect people's rights and worked appropriately to do so.

People's health and dietary needs were met effectively.

Good

Is the service caring?
The service was caring

Staff spoke, wrote and acted in ways which respected people's dignity and privacy and supported them to be as independent as they were able.

People were involved in their care and were supported to make choices and decisions about it.

Good

Is the service responsive?
The service was responsive

People's needs were identified within a comprehensive assessment and the resulting care plans were detailed and addressed the full range of their needs. Care plans were regularly reviewed involving the person and their representatives.

Transitions between the service and others were managed flexibly and responsively according to the person's needs. Changes in people's needs were addressed in a timely way.

The views of people, relatives and external professionals were sought and acted upon. People had regular access to activities and to the local community.

Good

Is the service well-led?
The service was well led.

The manager and provider monitored the service effectively and sought to develop and improve it.

Staff were well managed, motivated and understood the provider's ethos and the service values.

Good

Chilmington 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 inspection took place on 14 April 2015 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help us plan the inspection. We contacted two health professionals, nine local authority care commissioners and the Deputies Office and received feedback from some of them about the service. The Deputies Office within the local authority represents the financial interests of three people at the service.

During the inspection we spoke with two staff, the registered manager, deputy manager and assistant deputy manager. We also spoke with one person using the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care plans and associated records for three people, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools.

Good

Is the service safe?

Our findings

One person in the service told us: "I feel safe, yes". People's reactions to staff suggested they felt safe and trusted the staff who were working with them. We saw many examples of warmth and positive interactions and people were relaxed and happy around the staff. Some people actively sought out the company of staff.

Most of the people had known each other for a number of years and were familiar with each other. One new person had been admitted to the service since the last inspection. Staff were providing one-to-one support for an initial period of six weeks to support the person to feel safe and secure and settle into the service. Therefore the usual staffing had been increased to four staff on duty throughout the daytime, with two night staff on duty awake per night. Additional staff were provided where necessary to support activities or outings. Staffing levels were determined by the registered manager and registered provider in line with individual needs assessments.

The staff compliment of the home was sufficient to provide these staffing levels, supported by the provider's in-house casual staff 'bank'. No agency staff had been used for the two months prior to the inspection. The service's staff were offered additional hours as the first option to maintain continuity and consistency.

Staff had received training on safeguarding vulnerable adults and whistle-blowing from one of the management team. They were aware of things that could constitute abuse and neglect and told us they would report any concerns. There had been no safeguarding concerns reported about the service since the previous inspection.

People's safety was also supported because staff had received training on moving and handling and medicines management and had their competency assessed, to ensure they did not put people at risk. A care manager from one local authority told us: "The manager [and] staff are good at reporting any safety concerns".

Each person had individual risk assessments in place to address identified risks, which were regularly reviewed, most recently in March 2015. An individual fire evacuation risk assessment had been complete for each person. These reflected people's support needs in the event of a fire and identified any equipment required to support their evacuation. Two people had significant impairment of sight and/or hearing and this was also reflected in their risk assessments.

Each person had an individual accident log book on file which recorded any accidents. These were supported with body maps to record any bruising. The log book showed steps had been taken to prevent or reduce the risk of a recurrence.

Since the last inspection two staff had left and three new staff had started working in the service. The recruitment records for the two most recent recruits were checked. They contained the required evidence of the recruitment process including references, which had often been verified by telephone and a check of any past criminal record. However, their employment history had not been fully detailed, leaving some unexplained gaps. The manager had previously identified this issue in an audit of recruitment files and had asked staff to provide information about any gaps in people's employment details.

The service supported all of the people with their medicines as none were able to manage this themselves. Medicines administered were recorded on medication administration record (MAR) sheets together with the quantities delivered. Each dosage was recorded by the staff member who administered it and countersigned by a second staff member to reduce the risk of errors. A further check was made at the time of handover, by the incoming senior. A medication fridge was available for medicines which needed to be kept below room temperature.

Two medication errors had occurred since the last inspection. The registered manager had investigated these instances and taken appropriate action. This had included reporting of the error, reassessment of medicines competency and discussion of the responsibilities around medicines, with all staff. The deputy manager had completed an audit of medicines records and storage in December 2014 which was countersigned by the registered provider as part of their audit checks

Good

Is the service effective?

Our findings

One person told us they were happy in the service, saying: "I feel happy now I'm settling in". They added that their room was alright and they liked most of the food. We saw that people were settled and happy and that their needs were met by the staff who obviously knew them well and were attentive to each person.

Feedback from local authorities about the service was positive. One local authority care manager was very happy with the way a person's transition into the service had been managed and the care the person was receiving. Another care manager told us: "The staff and manager appear to be skilled and operate in a person centred way".

Staff were aware of how each person communicated their wishes and feelings and this was also recorded in their files. Information was also provided on how each person was able to make decisions and choices and how to support this. People were enabled to choose the staff who they wished to support them with personal care through the use of photos. Arrangements were being made to enable one person to have contact with a relative who could not visit, by means of a computer video programme.

The service had a written induction record which recorded the completion of each stage of the process and was signed off on completion. The most recent recruit had begun the new nationally recognised induction process with the registered manager as their mentor.

Staff were provided with a programme of core training to equip them to support people in the service. Additional specialist training was also provided when needed, for example on feeding via stomach tube and working with sensory impairment. Where necessary training was supported by observations of practice and the completion of written booklets to test understanding and check competency. Staff had received recent updates to core training apart from two instances which the registered manager said would be addressed as a priority. The service had a well-qualified team. Eighty two percent of staff had either attained a certificate in the National Vocational Qualification (NVQ) or equivalent, or were working towards this.

In addition to formal training courses and DVD based training, topics were introduced within team meetings for discussion and staff were asked to complete question booklets to check awareness.

The registered manager told us staff attended supervision meetings on a six to eight weekly basis and had annual practice appraisals. Some of the supervisions consisted of observations of aspects of care practice, which were subsequently discussed with individuals.

Senior carers and the management team provided out of hours support on a rota basis. Staff were also supported through attendance at regular team meetings. Information was passed from shift to shift through handover meetings to help maintain effective continuity of care. We saw these included reference to the wellbeing of each of the people in the service and any changes in their needs such as medicines.

People's capacity had been assessed under the Mental Capacity Act 2005 (MCA) and none were felt to have full capacity for decision-making. However, where people could consent to their care or make day-to-day decisions and choices this was made clear and was effectively supported by staff. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests.

Where people were unable to make major decisions affecting their wellbeing due to a lack of capacity, 'best interests' discussions had taken place involving appropriate professionals or family members to agree how to proceed. These were recorded in people's files. One person had a 'best interest' decision recorded about involving a dietician in their care and another person had one relating to covert medicines administration. No one had family members with 'power of attorney' to allow them to make care decisions on behalf of people. One person had a relative who had regular contact with them, with whom care decisions were appropriately discussed.

One person had a relative who was authorised as an appointee to manage their finances on their behalf. Others had local authority 'Deputies' who managed their finances. We received positive feedback from a local authority

Good

Is the service effective?

'deputy' who told us the service sought authorisation appropriately for spending funds on people's behalf and provided the necessary information to enable a decision to be made.

Where people are unable to leave a service safely without supervision or have other restrictions placed on them, a service must apply to the local authority for a 'Deprivation of Liberty Safeguards' (DoLS) authorisation. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. The service had applied for a DoLS authorisation for each person as none would be able to leave the building safely without support and each had been authorised.

Each person needed some support at mealtimes, with feeding, cutting up food, pacing or prompting. The person's support needs were described in their care plan. One person was fed direct via stomach peg tube and staff had been trained on this process and been signed off by the specialist nurse as competent.

Advice had been sought from a dietician and from the Speech and Language Therapy (SALT) team where necessary around choking risks. Appropriate risk assessments were on people's files. Staff had also been training on how to respond to choking incidents. Sufficient staff were available at lunchtime to meet people's support needs.

People chose what they wanted to eat at mealtimes from a range of options, based on their known preferences and any dietary advice. If anyone didn't want their meal an alternative was prepared. Staff had tried to assist people to make choices using photos of foods but this had not been effective. Instead people were often shown the actual items to choose from. Records of food eaten were kept for each person and fluid intake was also monitored for three people.

People's health needs were well met by staff. The support of GPs, district nurses and other health practitioners was evident from people's files and was always sought promptly. Special mattresses had been obtained for two people at risk of developing pressure damage and their skin was carefully monitored. Support had been sought from psychiatric services for one person where there was concern over the possible development of dementia. People's health was discussed in team meetings to ensure that all staff were aware and that any concerns were shared. The service advocated for people to ensure they received the healthcare and medical tests they needed.

Good

Is the service caring?

Our findings

One person told us the staff looked after them well and said: "The staff are nice here". People responded positively to contact from staff and staff spoke to them as adults and offered encouragement and support. Staff also supported people proactively when individuals were showing signs of anxiety.

Staff spoke respectfully about people during the handover meeting held between working shifts and passed on relevant information about changes in people's wellbeing. The terminology used in people's personal records was also respectful, positive and professional.

The registered manager had completed a 'dignity in care' monitoring questionnaire as part of her monitoring of how people's dignity was supported in the service. The document identified examples of good practice including advocacy on behalf of people and putting their needs at the centre of planning and organising the service. Members of the management team also observed care practice as part of their supervision of staff and their observations were discussed in supervision meetings.

Two members of staff were appointed as 'dignity champions' and received training so they could train other staff on supporting dignity in care practice. Staff had already completed questionnaires around dignity and attended a training session. Dignity and involvement issues had also been addressed in team meetings. In one meeting the visits of external advocates to support people, was discussed. Staff had also discussed working to safeguard the privacy of one person who was blind and partially deaf as unexpected intrusions into his personal space could be unsettling. People's confidentiality was respected and discussions about them took place in private. Care records were kept locked away when not in use.

An aromatherapist visited the service once or twice a week to provide support for two people around relaxation and sensory stimulation. One person's sessions were carried out in their bedroom to support their privacy. The other person preferred to be seen in the lounge and this too was respected. The aromatherapist had been given the necessary information about people to enable her to meet their needs. She also felt the service and the staff were caring.

Feedback from local authority care managers was also positive. One told us: "The staff come across as caring. My client is treated with dignity and respect" and added: "My client and [their] family are included in any decisions about care". One of the local authority "Deputies", told us: "The home itself has a lovely atmosphere and the staff appear to be very caring whilst still encouraging the service user's individual level of independence". The local authority commissioning team had no concerns about the care provided by the service.

People were involved in choosing which staff supported them with their meal or personal care using photos of the available staff. Wherever possible we saw that staff involved people in their care and encouraged choice and decision-making. This was also reflected within people's care plans. They identified people's wishes where known and described clearly how the person showed whether they were happy with something or not. One person was encouraged to drink their tea for themselves and others were supported with this where necessary.

Staff explained to people what needed to be done and sought their agreement before proceeding. They checked if people were comfortable and whether they needed anything. For example, a staff member explained to a person that it was lunchtime and checked they would like to be taken to the table. Staff spent additional time to explain things clearly to one person who was blind and had partial hearing loss to ensure they understood what was happening and what they were going to do. Where necessary, staff repeated their explanations or prompts to involve people as much as possible.

One person's birthday was due later in the week and a staff member spoke to them about this and talked about their birthday tea and the planned visit by a family member, then they sang happy birthday together. Staff were good at acknowledging other people in passing when they were supporting someone, so they too, felt care for and noticed. Other cultural and individual events significant to people were celebrated. The service had increased people's engagement with the community and social activities. Staff were aware of the implications of sensory impairment on people's engagement in activities and how to support them to feel involved and reduce anxiety.

Good

Is the service responsive?

Our findings

The service had received positive comments from relatives about the care provided. One relative said how well a person had been looked after while in the service. Another person's family had actively pursued a respite placement for them in the service. We saw that staff responded promptly to people's needs and anticipated potential issues well. Staff were talking to and engaging with people regularly and those not actively involved were acknowledged and their wellbeing checked. Staff offered one person a lot of reassurance in response to their anxiety and maintained their support in accordance with the person's care plan. Staff explained to one person that the member of staff they were asking for was busy, but they were told when the staff member was going to be available.

People's need had been assessed and recorded within a detailed preadmission assessment document. The resulting care plans were detailed and included information about people's support needs and how individuals communicated their wishes and feelings. They contained detailed guidance on how to work with each person based on their needs. Additional detail was provided on supporting those with sensory impairments and for the one-to-one support in place for one person. Care files included information about people's likes and dislikes, what individuals wanted and how to support them with that.

Care documents were centred on the person and identified any health needs and how these were to be met. Charts monitoring aspects of diet, health, weight were on file and up to date. Records of health appointments showed that healthcare was appropriately addressed. The care plans were supported by relevant individual risk assessments which identified any action to address identified risks. People's care plans were reviewed at least every six months and were updated with any changes in between. People and their representatives were involved or consulted appropriately.

The registered manager had previous experience of working with sensory impairment. She had trained staff about the additional needs of people with significant sensory impairment. Staff told us that the training had been powerful in enabling them to experience what that could be like. We saw that staff provided additional explanation to people in response to this.

One person had recently moved into the service. A detailed and flexible transition plan had been created to ensure that the stress of moving into a new service was minimised. The plan was adjusted in response to the way the person was responding to the visits. The person was settling into the service well. Additional staff support had been provided initially to reduce anxiety and help them settle in.

The service responded positively when individual needs were identified. For example by seeking funding to purchase specially adapted seating or wheelchairs in consultation with external specialists. Referrals had also been made to external health professionals where needs had been identified, including physiotherapists, occupational therapists and the mental health team. The service also has two adapted vehicles to support people to access the community irrespective of physical disabilities.

The service was responsive to people's changing needs. For example, one person has been found to be increasingly at risk of falls. An assessment was already under way for the use of a hoist when supporting them. Another person sometimes refused to take essential medicines. A 'best interest' decision had been agreed with the appropriate people for the medicines to be administered covertly, in the event of refusal, to maintain their health and wellbeing.

People took part in a wide range of activities, attended clubs, college and day services and spent time out in the community with staff support. One person particularly enjoyed swimming and this was supported via an independent day service. Some people had chosen sensory activities provided by a visiting aromatherapist.

Staff offered people choices in different ways to support their independence, often using the actual objects such as drinks, or photographs, for example of available staff. They had found that photos of food items were not very effective so tended to show people choices directly, for example a selection of yoghurts. People also chose when they got up and went to bed. Two people regularly opted to stay up until midnight and this was supported by staff.

People's care plans and records referred to them being offered choices about clothes and activities and we saw this was done. People chose which staff supported them with personal care or with meals. People had been involved in the recruitment process for new staff. This was through meeting potential candidates in the service as part of their interview process.

Good

Is the service responsive?

The complaints records showed no complaints in the previous 12 months. One person would be able to raise a concern themselves. Others would need the support of staff or others to make a complaint. Two people had family who visit them and would raise any issues on their behalf. Each of the people had access to an independent advocate who visited them regularly and would advocate on their behalf if there were any concerns.

A therapist who visited the home told us they had no concerns and could approach the staff or manager if they were to have any. The local authority also told us they had had no concerns about the service. The local authority care manager for one person told us: "[Name] is supported to take part in activities of [their] choice. Staff have provided good ideas to stimulate [Name's] interests." The local authority financial representative for some of the people told us the service was proactive in seeking funds for necessary items and: "Considers the service user's changing needs".

A survey had been issued to families and external care and health professionals in December 2014 to see their views about the care provided. The service had pictorial versions to try to seek feedback directly from people by reading through it with them. However, only one person had been able to provide any feedback using this. The feedback received about the care was very positive.

Good

Is the service well-led?

Our findings

Staff understood their role in the team and were motivated and enthusiastic in the way they worked. Staff were very much focused on people's needs and responded in a timely and appropriate way to these. Relationships between staff and management were positive.

A representative of the local authority told us: "The Manager appears to have good leadership skills with the staff and an understanding of the values of the provider". Other local authority representatives praised the way the service was run and one told us: "We have had no quality issues with them".

Members of the management team worked on shift and informally monitored day-to-day practice. Any concerns were raised with individual staff in supervision or discussed in team meetings. Staff felt able to contribute to discussions and ask questions if necessary and had reported to management if they had any concerns about colleagues. Staff told us that team meetings were open and constructive. Reflective practice was discussed in team meetings and also as part of the 'dignity in care' process to monitor and continually improve the focus on people's individual needs and wishes. Staff had completed questionnaires on dignity and had also attended experiential training on the impact of dual sensory impairment.

Where issues were identified by the management team they were included on the team meeting agenda for discussion as well as being addressed individually where necessary. Keyworkers also ensured that information about changes in people's needs or wellbeing were shared between the team members.

The registered manager had attended a conference regarding the changes in the regulations applicable to the service and a copy of the new regulations was available on site.

The service had a written business plan for the period December 2014 to November 2015. This identified the visions and values of the service, its strengths and identified areas for improvement. Target dates were set and monitored. The goals included ensuring that staff were aware of their roles and responsibilities and any changes in legislation affecting them. Other goals included ways to provide staff with a rewarding and flexible work life and maintain training opportunities. The document also highlighted the importance of maintaining the lifestyles of the people it supported. A staff newsletter had been introduced and was first published in October 2014. This kept staff up to date on key changes affecting them.

A separate 'Workforce Development Plan' for the period April 2014-2015 was also in place. This ensured that staff training and support were monitored and managed. Staff each received a staff handbook which stated the aims and ethos of the service and identified the quality of life principles followed. Staff worked positively in accordance with these principles.

The provider regularly visited the service. The registered manager and provider maintained a quality monitoring audit process which was recorded. The reports noted any issues with regard to premises, practice, records or people's needs and identified and followed up on any necessary actions.

The registered manager maintained a range of monitoring systems to oversee things including staff supervision and appraisal and training. Accidents were monitored by keyworkers and also by the management team. Action was taken where a particular cause was identified. For example, one person had been identified as at risk of banging themselves on their wheelchair footrests. A specialist footplate had been obtained via a referral to the occupational therapy service, together with a pressure cushion and protective heel pads.

The registered manager had also carried out an unannounced visit in June, September and November 2014 to monitor night time care practice. Records showed that any issues found had been followed up. The service had identified medication errors through its monitoring processes and had investigated and taken appropriate action to reduce the risk of recurrence.

The service was also subject to regular local authority quality monitoring visits and visits by the local authority financial 'deputy' who managed people's funds on their behalf. No issues of concern had been reported.

Care and other records were kept in an orderly and systematic fashion so it was easy to locate specific information quickly. Documents were reviewed regularly. The registered manager had ensured that notifications had been submitted to the Care Quality Commission where

Good

Is the service well-led?

required. For example, about the making of DoLS applications on behalf of people. A notification is information about important events which the service is required to tell us about by law.