

The Disabilities Trust

Chalkdown House

Inspection report

Edison Park
Hindle Way
Swindon
Wiltshire
SN3 3RT

Tel: 01793429630
Website: www.thedtgroup.org

Date of inspection visit:
13 June 2017

Date of publication:
03 July 2017

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

We inspected the service on 13 June 2017. The inspection was unannounced.

Chalkdown House is a specialist neuro-behavioural service for people with a non-progressive acquired brain injury. The service provides specialist rehabilitation. Chalkdown House was previously registered with the Care Quality Commission as an independent hospital. Prior to the inspection the provider applied to register as a care home providing accommodation with personal care. This was the first inspection carried out under the adult social care registration. The service was registered to provide support for up to 20 people, which included two self-contained flats. At the time of the inspection there were six people living in the service.

There was a registered manager in post. 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.

At the previous inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. Records relating to people's observations were accurate and complete. Staff had completed training appropriate to their role and were competent to support people using the service.

The staff team were uncertain about the future direction of the service, especially following the recent changes in registration; the provider was aware of these concerns and was working to provide support to staff.

The registered manager promoted an open and transparent culture in the service. Although there were anxieties within the staff team, staff maintained a focus on people to ensure their needs were met and they were not unsettled by any changes.

The service was concentrating on discharge planning for people using the service. The management and staff team were working closely with people, relatives and commissioners to identify suitable onward placements.

People were safe in the service. Risks to people were identified and managed. People were supported to be as independent as possible. Positive risk taking was identified to improve people's independence and well-being.

Medicines were managed safely. People received their medicines as prescribed and there was clear guidance for staff where medicines had specific instructions relating to administration.

There were sufficient staff to meet people's needs and to enable them to access activities both within and

outside the service. Staff understood their responsibilities to identify and report any concerns relating to abuse.

Staff felt valued and listened to by the management team at the service. Staff were supported through regular supervision.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported by caring staff who had a clear understanding of people's complex needs. People were treated with dignity and respect and were involved in all decisions about their care.

There were a range of clinicians employed in the service. Where needed people were supported to access additional specialist to ensure their health and well-being was maintained.

Care plans were detailed and contained a wealth of information about people's needs. However, it was not always easy to find information and some information was duplicated.

People and their relatives knew how to complain and were confident to do so. Complaints were investigated and responded to in line with the provider's policy.

There were effective systems in place to monitor and improve the service.

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 had improved to good and was safe.

Staff understood how to identify and report concerns relating to abuse of vulnerable people.

Risks to people were identified and plans were in place to manage the risks.

There were effective recruitment systems in place to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good ●

The service was effective

Staff were supported through regular supervision and had training to ensure they had the skills and knowledge to support people's needs.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA)

People received food and drink to meet their nutritional needs.

Is the service caring?

Good ●

The service was caring.

People were involved in decisions about their care and decisions were respected.

Staff were kind and showed empathy to people.

Staff took time to get to know people and developed trusting relationships with them.

Is the service responsive?

Good ●

The service was responsive.

Care plans detailed people's support needs and gave clear

guidance to staff in how to meet those needs.

People had access to a range of activities of their choice.

People and their relatives knew how to make a complaint.

Is the service well-led?

Good ●

The service had improved to good and was well led.

There was an open and transparent culture at the service.

The registered manager provided support and guidance to staff who felt valued and listened to by the local management team.

There were effective systems in place to monitor and improve the service.

Chalkdown 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 13 June 2017 and was unannounced.

The inspection was carried out by three inspectors and a specialist advisor who had specialist knowledge of people living with an acquired brain injury.

Prior to the inspection we looked at information we held about the service. This included previous inspection reports and statutory notifications. Notifications are specific events the provider is required to tell us about.

We spoke with two people and three people's relatives. We spoke with the registered manager, the deputy manager, a psychologist, a physiotherapist, a health and fitness coach, a speech and language therapist, a nurse, four clinical support workers and the chef.

We looked at the observation and medicine records for the six people using the service. We looked at four people's care records and other records relating to the management of the home.

Is the service safe?

Our findings

At our inspection in June 2015 and focused inspections carried out in January 2016 and April 2016 we found that staff did not receive training to ensure they had the skills and knowledge to support people safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. The registered manager kept a record of the training staff were required to complete dependant on their roles and responsibilities. The training records identified the training staff had completed and when they were due to update their training. This ensured staff had received training to enable them to support people in a safe way.

Relatives told us they felt people were safe at Chalkdown House. One relative said, "Yes, he is being kept safe".

Staff completed training in safeguarding adults and had a clear understanding of their responsibilities to identify and report any concerns. One member of staff said, "Any changes in service user behaviour, or marks might indicate something. I would report it to the head of care".

Although staff did not know the details of who they could report to outside of the organisation they were aware of where that information could be found. There were posters around the service displaying information for staff about how to raise concerns which included telephone numbers.

There were sufficient staff to meet people's needs. Where people required one to one support we saw this was always provided as per people's care plans. The provider had effective recruitment systems in place. Staff records showed checks had been carried out to ensure staff were suitable to work with vulnerable people. Checks included Disclosure and Barring Service checks (DBS) and references from previous employers. These checks enabled the provider to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

People's care records contained a range of risk assessments. Risk assessments included risks associated with: Epilepsy; self-harm; suicide; falls; self-neglect; aggression; choking and tissue viability. Where risks were identified there were plans in place to support people and staff to manage the risks. For example, one person was at risk of experiencing seizures. The care plan gave clear instructions relating to how the person would present when having a seizure and the actions staff should take in response. The risk assessment and care plan was reviewed monthly to ensure the guidance was up to date and accurate.

Risks associated with behaviour that may be seen as challenging to people or others were identified and care plans gave guidance to staff in how to manage those behaviours. Staff carried emergency alarms to ensure risks to their safety were managed. One member of staff told us, "I have a personal alarm which is responded to really quickly. It makes me feel safe".

Positive risk taking was encouraged to improve people's quality of life and independence. For example, one person wanted to go out alone. The staff had worked with the person to identify an area where they would

be safe to be out alone. Staff accompanied the person to the area and then waited for them to return. There were plans in place should the person not return. However, this had not happened.

Medicines were managed safely. People's medicine administration records (MAR) contained details of all prescribed medicines and where there were special instructions relating to the administration of medicines these were detailed and attached to the MAR. Most medicines were in a monitored dosage system (MDS). There was an auditing system that monitored the balances of medicines not in a monitored dosage system. We checked these and the balances were correct. Staff documented a reason if a person did not take their medicine.

Where people had been prescribed medicine to be administered on an 'as required' basis (PRN), there was guidance in place to ensure the medicines were administered as prescribed. Records showed when PRN medicines were administered and the reasons for their administration. This ensured people's behaviours were not controlled by excessive or inappropriate use of medicines.

Medicines were stored securely in locked trolleys and kept at an appropriate temperature.

The provider had a medicines policy in place which included procedures to follow in the event of a medicines error. There was a robust system in place to manage the ordering and disposal of medicines. Staff responsible for the administration of medicines had received training in the safe management of medicines. Staff competency to safely administer medicines had been assessed and this was completed annually.

People were protected from the spread of infection. Where people were diagnosed with a condition that required additional infection control measures this was documented in their care plan. For example, one person's care plan identified a condition, detailed how the infection could be transmitted and provided guidance to staff on the infection control procedures needed. Staff we spoke with had a clear understanding of the procedures they should follow.

There were systems in place to monitor the environment and equipment to ensure it was well maintained and safe. There were regular checks and tests on all equipment in the service, including weekly fire alarm tests. All equipment had been serviced within timescales. As a result, people were protected from potential risks caused by faulty equipment. When staff reported any maintenance requirements and issues, these were resolved in a timely manner.

Is the service effective?

Our findings

Staff were confident they had the skills and knowledge to meet people's needs and were able to access additional training to improve their skills. One member of staff told us, "I have always been supported by [registered manager] to access training". Staff completed a range of training which included: health and safety; food safety and nutrition; moving and handling; brain injury awareness and physical intervention.

New staff completed an induction programme which included: e-learning; face to face training; shadowing more experienced staff and reading people's care plans. One member of staff told us, "It (induction) was good. I did all the training before going on the floor. Then I worked alongside someone else until I was confident". Staff had regular meetings during their probationary period and a probation meeting at the end of the probation period to ensure they were competent to be permanent staff.

Staff felt supported and had regular supervision meetings with their line manager. One member of staff told us, "I have meetings about every eight to 12 weeks but I can talk to [line manager] in between if I need to. There is always someone you can go to if you need help". Supervision records showed that where issues were identified staff were supported through supervision to reflect on their performance and supported to improve. For example, we saw that one member of staff needed some training around brain injury. We saw in the next meeting records that this training had been attended.

Most members of the clinical team had regular supervision with an appropriately trained supervisor. Due to the changes taking place at the service and the uncertainty over the future, not all clinical supervision was taking place. One clinician told us they did not have any structured clinical supervision but had informal supervision and support from other clinicians and the registered manager.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA) and their rights were protected. MCA 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. Staff had completed training in MCA and had a clear understanding of how to work to the principles of the act. One member of staff told us, "We always let them make choices. We respect their rights".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that where people were assessed as lacking capacity to consent to restrictions in relation to their care needs applications for DoLS had been made to the supervisory body. Conditions on authorisations were being followed. For example, one person had an authorised DoLS in place for a specified time period to enable assessments to be carried out. These assessments were in the process of being completed.

People had access to food and drink to meet their needs. People's preferences were considered and a

dietician was involved in menu development. Independence with meals was encouraged. There was a self-service breakfast between six and ten in the morning. The breakfast included cereal, fruit and porridge. Tea and coffee was available in the dining room and refreshed throughout the day. Two options for lunch were always provided and food items were available for people when the chef was not present.

People had access to their own kitchen. A sandwich group was held each week to encourage social interaction. The kitchen was used to increase skills to live more independently. For example, one person was keen to eat more healthily and was supported by a dietician to shop and make their own lunch.

We spoke with the chef and kitchen assistant who had been in the service since it opened. They explained they had weekly food theme nights which had included a Spanish evening with paella, smoked paprika chicken and patatas bravas. This had been enjoyed by the people using the service.

People's records showed that there was effective multi-disciplinary team (MDT) working taking place. Care plans included advice and input from different professionals involved in people's care. People had access to the range of professionals employed by the service and were supported to access additional support when needed. For example, records showed people had been supported to access G.P's and attend hospital appointments.

Is the service caring?

Our findings

Relatives were complimentary about the staff supporting people. Comments included: "I've been very pleased with the care staff. They're very kind" and "They are definitely caring. They don't force him to do anything. He always looks happy and settled".

Staff had a caring approach to their role and the people they supported. Staff comments included: "They (people) are involved in everything. They are treated with respect. I think the people here get great care" and "Service users are very well supported. It's all about them. As long as they are happy, that's what matters".

When new staff started working at the service they were introduced to people slowly to enable people to get to know them before they provided support. This enabled people to develop relationships with staff in a positive and supportive way. One member of staff told us how they and developed their relationship with one person. They said, "He accepts me now. There are some things he won't let me do and I respect that".

Due to the complex needs of the people using the service people often rejected specific staff members. The service respected people's choices and the management team supported both people and staff members to manage these situations.

Staff supported people to be as independent as possible. One member of staff said, "We have to make sure we let them be as independent as they can be". For example, some people were encouraged to cook their own meals.

People were supported to access advocacy services in relation to decisions about their care and support needs. An advocate supports people to ensure their views and wishes are genuinely considered when decisions are being made about their lives.

People were involved in all aspects of their care and support needs. Care plans showed people's views were sought and considered when setting goals people wished to achieve. For example, one person had an aggression care plan. The person had agreed the goals and levels of interventions that would be used in relation to an escalation in their behaviour.

Relatives told us they were involved in decisions about people's care and were kept informed if people's condition changed. Relative's comments included; "They are very good at letting me know what's going on" and "The appropriate people contact me depending on the issue".

The service was in the process of supporting people with discharge planning. People and their relatives were closely involved in the planning and all decisions being made. One relative told me, "I am very involved in planning his discharge". The relative told us they had visited suggested alternative accommodation and had been consulted in relation to potential areas of the country that would be accessible for visits.

Is the service responsive?

Our findings

People had extensive assessments carried out prior to admission to the service. These assessments were used to develop care plans that detailed how people's needs would be met. Care plans were not always easy to navigate and contained duplicate information. Whilst all the information relating to people's health and social care needs was available it was not easy to find. Staff told us care plans were difficult to use and needed to be streamlined.

People's care plans were not always personalised. Care plans were developed on the risks identified and did not always reflect the person-centred approach of the service.

We spoke to the registered manager who told us the provider was reviewing the care plan format to improve its effectiveness. However, as people were being moved from the service it was felt that any changes would be implemented when new people accessed the service.

People's needs were regularly reviewed to ensure their needs were being met. There were weekly multi-disciplinary meetings to discuss people's progress. At the time of the inspection the focus was on discharge planning for the people in the service. One member of staff told us that discharge plans were difficult due to the complexity of the people using the service. They said, "We are actively looking for somewhere that will meet the service user's needs. We are not just discharging anywhere".

People were supported to maintain relationships that were important to them. Relatives told us they were welcome to visit at any time and the service supported people to visit their relatives. One person was supported to have contact via an internet video link each week. The person's relative told us, "I Skype him once a week. The staff give me a call beforehand to give me an update on how he's been".

People were supported to access a range of activities both within and outside the service. For example, on the day of the inspection one person had gone to the cinema. One person's relative told us that activities had improved over the last 6 months. They said, "He's been to the pub and to concerts".

One person who chose not to socialise with other people lived in a flat within the service. The flat overlooked the gardens. The person had a keen interest in nature and had access to part of the grounds to tend their own garden.

The service employed a vocational planner who worked with people to plan social activities and supported them to access the activities. Each person's planned activities were displayed in the office so that staff were aware of the activities taking place. The registered manager told us that it was necessary for the plans to be flexible to accommodate the complex needs of the people.

The service also employed a health and fitness coach who worked closely with the physiotherapist to help people achieve their goals in relation to their physical well-being. The health and fitness coach had successfully engaged five of the people using the service in rehabilitation programmes.

People were encouraged to maintain and improve their independence. The service was currently working with some people at the service to move to more independent living with support in their own home. People and their families were involved in the decisions being made. One relative told us, "They've been very helpful in finding a new placement. They have helped me find the most direct route to the new service".

The service sought feedback from people and relatives. There had been no responses to a recent quality assurance questionnaire. The registered manager explained they were now arranging one to one meetings with people to encourage them to give feedback. This had resulted in feedback identifying people did not always know who key staff were. The registered manager had written a letter to people explaining who staff were and their role in supporting people.

People and their relatives knew how to make complaints and felt confident to do so. One relative told us, "I report any concerns to [registered manager]. She is very nice and helpful and takes up [person's] complaints". Records showed that complaints were investigated and responded to in line with the provider's complaints policy. Throughout the service there were posters displaying the contact details for the Care Quality Commission (CQC) should people wish to raise concerns.

Is the service well-led?

Our findings

At our inspection in June 2015, January 2016 and April 2016 we found observational charts were not being fully completed in line with guidance in people's care plans. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. We looked at the observation care plans and observation records for the six people using the service. Care plans gave clear guidance to staff relating to the observations people required and all observation records had been completed in line with people's care plans. For example, one person required one to one observation from 9am to 5pm, observation every 30 minutes from 5pm until the person was asleep and one hour observations when they were sleeping. We saw that observations during one to one observations were recorded on an activity record and all other observations on the observation record.

The service was experiencing a period of transition following the change in their registration with CQC. This had created a significant amount of anxiety for staff who were not clear about the future of the service. Staff comments included: "We were just told the nurses were going. We've not been told anything by the organisation. We've no idea what's happening"; "The worse thing is communication at the moment. Organisational communication is poor"; "There has been poor management of the changes. I am disheartened by the Trust and their total lack of support"; "This makes me anxious (lack of information). The team are supportive and approachable. This issue is with support from above" and "There is a lot of uncertainty. The team are not clear what is happening from above". Staff were confident that this did not impact on people using the service. One member of staff said, "Service users are well supported and not unsettled".

We contacted the provider about the concerns raised by staff relating to the future direction of the service. The provider told us, "We are aware of these concerns and are providing management support while we work with funders to understand future commissioning requirements". They advised us that a divisional manager was in the service each week providing support and a visit by the interim director had been arranged.

Relatives were complimentary about the management team at the service. One relative told us, "I can't fault Chalkdown. They are brilliant".

The registered manager promoted an open culture in the service. The registered manager told us, "I always say to service users and staff, if you've got a problem I need to know about it so I can do something about it".

It was clear people were valued as individuals and were at the centre of all the service did. The registered manager was committed to finding the most appropriate placement for people leaving the service. The management team were working closely with people, their relatives and commissioners to source alternative placements.

Staff felt valued and supported by the registered manager and deputy manager. There were regular staff

meetings where staff were encouraged to share ideas and discuss issues. Staff comments included: "Yes, I am listened to. Everybody has a chance to say what they think. If you don't want to say in a group you can do it one to one"; "I like it here, knowing you always have support. [Registered manager] has been very supportive"; "[Registered manager] is lovely; very, very fair. The head of care is brilliant we can go to her with anything".

Records of staff meetings showed that where issues were identified action was taken to improve the service. For example, it was identified that staff were not always clear where emergency equipment was kept. The head of care had led the development of a booklet that gave clear guidance to staff in relation to emergency equipment.

There were effective systems in place to monitor and improve the service. Regular audits were completed. These included: health and safety; environment; kitchen; staff files; service user files; medicines and infection control. There was also a quality assurance audit completed by the provider's quality assurance advisors. Where issues were identified action was taken. For example, the quality assurance audit had identified that a report containing confidential information was displayed on the notice board in a meeting room that was used by visitors to the service. Action was taken to remove the report and staff were advised that all future displays must contain only anonymised data. There was no confidential information on display on the day of the inspection.

Accidents and incidents were recorded and reported. This included where de-escalation and interventions had been used by staff when supporting people. Records showed appropriate action had been taken to minimise the risk of a reoccurrence and to identify any learning from the event. The registered manager reviewed all accidents and incidents to look for patterns and trends.