

Chalkdown House

Quality Report

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Date of inspection visit: 5 April 2016

Date of publication: 09/06/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



Summary of findings

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Requires improvement 

Chalkdown House

Services we looked at

Services for people with acquired brain injury

Summary of this inspection

Background to Chalkdown House

Chalkdown House is an independent hospital that provides specialist neuro-behavioural care for people with a non-progressive acquired brain injury. It forms part of the nationwide network of specialist rehabilitation services provided by The Brain Injury Rehabilitation Trust (BIRT), which is a division of The Disabilities Trust.

The service opened in May 2013 and is male only with 20 beds. There are two self-contained flats situated on the ward for patients nearing discharge.

The services at Chalkdown house include long term rehabilitation care; hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

Chalkdown House was first inspected in December 2014. This inspection included a full review of those patients' that were detained under the Mental Health Act. As a result of this inspection, Chalkdown House received two compliance actions as they were in breach of Regulations

9 Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010 the Care and welfare of people who use services and Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 and staffing.

We visited again on the 2 and 3 June 2015, the two breaches of the above regulations had been rectified. . However during our inspection on the 2 and 3 June 2015 we found breaches relating to Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect; Regulation 9 HSCA (RA) Regulations 2014 Person-centred care and Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. We revisited Chalkdown House on the 5 January 2016 to review the Chalkdown House action plan and were able to lift two requirement notices relating to Regulation 9 and 10 due to improvements. Although progress had been made with regards to Regulation 12, this remains in place with an additional action plan to complete. During the inspection in January 2016 we found concerns relating to the recording of patient observations and as a result issued an additional requirement notice under Regulation 17 HSCA 2008 (Regulated Activities) 2014: Good Governance.

Our inspection team

Lead Inspector: Lisa McGowan

Chalkdown House was visited by two CQC Inspectors.

Why we carried out this inspection

This inspection was a follow up visit from a focused inspection that was undertaken in January 2016. We specifically looked at the recording of patient observations in line with the organisations policy and procedures and CQC action plan. We did not inspect any

other areas of care on this occasion. Currently, the ratings that were awarded at the time of the comprehensive inspection in June 2015 remain, which overall was an outcome of requires improvement.

How we carried out this inspection

Before the focused inspection visit, we reviewed information that we held about these services.

During the inspection visit we:

- reviewed 11 records relating to patient observations
- spoke with the acting deputy manager for the service and the divisional manager.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found improvements had been made with the recording and monitoring of observation records.

Requires improvement



Are services effective?

We did not inspect any areas relating to effectiveness during this inspection.

Good



Are services caring?

We did not inspect any areas relating to caring during this inspection.

Good



Are services responsive?

We did not inspect any areas relating to responsive during this inspection.

Requires improvement



Are services well-led?

- We found audits to show that the monitoring of patient observations and staff adherence to the observation policy were in place and under regular review.

However:






The current observation policy did not reflect the changes made during the service review as to what minimum observation levels patients should be on.

Requires improvement



Detailed findings from this inspection

Services for people with acquired brain injury

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 

Are services for people with acquired brain injury safe?

Requires improvement 

Safe staffing

- Chalkdown House had recently recruited more staff. This was to fill existing vacancies and provide additional staff to carry out patient observations (patient observations are interventions performed by staff at regular intervals or on a continuous basis. They are used to keep people safe, engage with patients, know of patients general whereabouts and observe for any changes in mental and physical health).

Assessing and managing risk to patients and staff

- Since the last inspection in January 2016, Chalkdown House had undertaken a review of the observation needs of patients and applied levels of observations in line with patients level of risk. We found three patients who, following a risk assessment and ongoing regular reviews of risk, were not under any observation. We were told that as a minimum, staff used routine times during the day (medication and meal times) to ensure that these patients were well. Following the inspection we looked at the organisational policy for patient observations. This stated all patients would be observed on a minimum hourly basis for reasons of safety and well being. This was different from the practice where three patients were not observed regularly. This policy is now under review by the organisation.

Track record on safety

- We reviewed 11 patient observation records including patients receiving one to one observations and found records were incomplete. For example, staff signatures or the patients' activity information was missing. However, staff had observed all patients subject to observations within the correct time frames. These included time frames of 15, 30 and 60 minutes and two hourly checks, as well as observations under conditions of 1:1 care.
- Chalkdown House completed weekly audits to monitor the quality of the observation records. The weeks beginning the 18 and 26 March 2016 and the 1 April 2016 had audit scores of 100%. We reviewed the patient observation records in line with the outcome of these audits and found them to be correct.
- As part of an action plan from the previous visit in January 2016 Chalkdown House have submitted monthly information to the CQC regarding the practice and management of patient observations. In the months of February and March 2016 Chalkdown House identified when errors had occurred and where improvements were required. During this visit we reviewed the records relating to February and March 2016 and found them to reflect accurately what was being reported to the CQC. Chalkdown House will continue to report to the CQC until July 2016 at the earliest to ensure that sustained improvement has occurred.

Are services for people with acquired brain injury effective? (for example, treatment is effective)

Services for people with acquired brain injury

Good 

We did not inspect any areas relating to the effectiveness of services for people with acquired brain injury as part of this inspection.

Are services for people with acquired brain injury caring?

Good 

We did not inspect any areas related to caring as part of this inspection.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Requires improvement 

We did not inspect any areas relating to how responsive the service is for people with acquired brain injury as part of this inspection.

Are services for people with acquired brain injury well-led?

Requires improvement 

Good governance

- Since the last inspection in January 2016 Chalkdown House have been required to submit to the CQC monthly information relating to the practice and monitoring of observations. We compared this data to the relevant observation records and found that it was an accurate reflection of what had occurred.
- The provider's audits showed staff adherence to correct patient observations was in place. We reviewed the past three weeks audit information and found that all paperwork for this period was as it should be and the audit information reflected this.
- We were told by Chalkdown House management that some patients were not observed due to low levels of risk. However, we found differences between the policy and practice of observations. The organisational policy stated that all patients should be observed on a minimum hourly basis. We found on the day of our inspection three patients who were not on any observations. Although these three patients had been identified as low or no risk to themselves or others, Chalkdown House could not be assured that these patients were not always safe from accident or harm from others. This policy is now under review by the organisation.