The David Lewis Centre

Assessment and Treatment - Warford

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

This inspection took place on the 26 October 2016 and was unannounced.

The Assessment & Treatment Service provides specialist medical and therapy support to other David Lewis locations, primarily on the campus located at Warford in Cheshire.
Services include 24 hour nursing cover and a minor injuries clinic as well as a variety of other services such as diagnostics, neurology, occupational therapy and dietetics.

The last inspection took place on the 15 January 2014 and we found at that time that all the legal requirements were met.

The service has a registered manager. 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.

During this inspection we found that the service was well organised and managed, ensuring that robust arrangements were in place to provide medical and nursing cover for the people living on the David Lewis campus.

Risks to people using the service were regularly reported on and analysed. Where risks had been identified the service had been proactive in looking at potential causes and putting measures in place to try to reduce them.

There were clear and detailed policies for the administration of medicines, which enabled to staff to work autonomously to some degree for the benefit of people using the service.

Training was seen as being of extreme importance and all the staff we spoke with told us that opportunities for training and further development were excellent.

Staff were very aware of the need to gain consent from people using the service, prior to any treatment being given. They demonstrated thought and compassion in describing how they achieved this.

Records of all the care and medical interventions people received were held electronically and there were good systems in place for updating them and ensuring they were accurate.

The registered provider had a number of systems in place to ensure the quality of 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 was safe.

There were sufficient staff to provide the service and robust arrangements for the on call, out of hours service.

Medicines were managed safely.

Where people using the service were identified as being at risk, measures were put in place to reduce the risk where possible and these were kept under regular review.

Is the service effective?

Good

The service was extremely effective.

Staff had access to a wide range of training and valued the opportunities they were given to share best practice.

Staff were conscientious in ensuring people consented to their care and treatment.

Is the service caring?

Good

The service was caring.

Staff were sensitive to people's need for privacy when undergoing treatment.

Staff strived to ensure that people who had lived at the centre a long time could remain there when they were at the end of their life. Staff treated people as individuals and knew and respected their likes and dislikes.

Is the service responsive?

Good

The service was responsive.

Records of care and treatment were held electronically and were only available to those that needed to access them.

There were good systems in place for the exchange of

information.

The registered provider had established a corporate complaints' policy, which staff were aware of. Complaints had been responded to appropriately.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who was committed to managing a service that met people's needs.

The registered provider had created a clinical governance committee that met quarterly where risks, untoward incidents and deaths were considered.

These meetings also provided the opportunity for learning and reflection.

Assessment and Treatment - Warford

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 26 October 2016 and was unannounced. The inspection was carried out by one adult social care manager and one adult social care inspector.

Prior to the inspection we reviewed the information we held about the service. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law.

We contacted the local authority before the inspection and they shared their current knowledge about the service.

This service does not provide accommodation to people; it provides medical, nursing and allied professional services to the people living on the rest of the David Lewis site. Many of the people attending clinics have difficulty in communicating and it was therefore difficult to gain direct feedback from them. We gathered feedback from staff on the rest of the site about the level of support they got from staff at the Assessment and Treatment service and from some relatives who had had contact with the service whilst supporting people that lived on the campus.

We spoke with the registered manager, matron and other members of staff including two nurses, one doctor and a clinical physiologist. We looked at the audits and risk register and the records on the electronic system Icare. We also looked at staff rotas and training and induction records.

Good

Is the service safe?

Our findings

This service provides medical and emergency cover to the people living at The David Lewis Centre. There were two nursing teams.

One nursing team provided 24 hour centre cover. The team had a dual role, working with the GPs and practice nurses and also covering for emergencies outside of normal office hours.

The other team specialised in mental health and learning disabilities. This team comprised four nurses working Monday – Friday 7am – 9pm. They worked with local doctors in a multi-disciplinary structure. One of the nurses was a non-medical prescriber and a second nurse was soon to complete the training. The team was also made up of four physiotherapists, four speech and language therapist (SALT) and electroencephalogram (EEG) technician. Staff on this team were based in their own departments and treatment rooms. To support the Assessment and Treatment service as a whole there were also adults' and children's medical directors who both worked at the centre half a day per week, a neuropsychiatrist and a Children's and Adolescent Mental Health Services (CAMHS) psychiatrist that worked at the centre once a week and a paediatrician that worked at the centre once a fortnight. Four doctors worked at the centre full time and a dentist and chiropodist visited once a week and once a fortnight respectively.

Proactive work had taken place in response to risks identified to people living at The David Lewis Centre. We saw excellent examples of how staff were responding to improve people's safety. An example of this was the work that had been done around Sudden Unexpected Death in Epilepsy (SUDEP). This work had started as a result of one person that had died suddenly at The David Lewis Centre and the cause of death being cited as SUDEP. The registered manager had started to look at the risk factors associated with this and had developed a risk tool to identify people that may have an increased risk of sudden death due to epilepsy. This tool had informed practice and monitoring and was used by staff to determine what equipment may be needed to effectively monitor individuals at risk, for example using seizure mats, alarms and equipment that detected changes in respiration. It had been identified that people were exposed to more risk when their medication was changed so an action was that there would not be changes to medication for more than one person in a house at any one time, so staff could monitor effectively. Analysis of the statistics from last year to this year demonstrated that there had been a reduction in people dying where SUDEP was cited as the cause.

The matron of the Assessment and Treatment service showed us the risk register, which was kept electronically. This held details of all the people living on site and those that lived in the community and received services from David Lewis staff. A dashboard was completed, which identified those people on high risk medicines such as warfarin and also provided information about each individual's health conditions, recent hospital admissions, falls, risk of SUDEP, dysphagia, medical reviews, those on do not resuscitate directives (DNACPRs) or End of Life Care. Work was being undertaken to try to identify the houses on site where there was higher risk and staff were alerted to this so they could be extra vigilant.

Staff working at the Assessment and Treatment service administered medicines to people living in the

different locations that comprise The David Lewis Centre on an emergency basis in the evenings and at weekends. All nurses that undertook this task had received additional training in the use of Patient Group Directives (PGDs) specific to the individuals they were written for. Each PGD had examples of how to complete the documentation and clear protocols. The nurses could not administer emergency medicines to all people using the service in a blanket approach but could only administer medicines to those people where they had received the training specific to that person's treatment and care plan. Robust audits were in place to ensure all emergency medicines were accounted for and replaced when used.

Medicines that were used in the course of treating people coming to the unit were stored securely and stock was audited once a week by the night staff. The unit also stocked an anaphylaxis kit and defibrillator, both of which were checked daily. We saw clear documentation that recorded this.
Medicine training was delivered at three levels and staff undertook the levels of training in keeping with what was required of them in their role. The nurses working at the Assessment and Treatment service were also responsible for carrying out medicine competency checks for other staff on the David Lewis site.

Nurses were trained in advanced life support techniques as they provided emergency cover to all the sites within the David Lewis Centre. All on call staff at the Assessment and Treatment service had been given bespoke training unique to the David Lewis Centre to provide the required level of cover.

Staff told us that they received training in safeguarding children and adults as part of their initial induction and then received refresher training yearly. Staff were confident that they could recognise signs of potential abuse and were clear that they would report any concerns to the registered manager. However, several staff were less aware of their options to report concerns externally if they did not feel they had been addressed appropriately via their internal procedures. The David Lewis Centre have their own social work team and safeguarding manager to whom all safeguarding issues are reported in the first instance. We discussed with the registered manager the need to ensure that all staff understood the lead role of the local authority in safeguarding matters.

Staff confirmed that they had been recruited via a robust recruitment process, which required them to provide appropriate references and undergo a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions to try to prevent unsuitable people from working with children and vulnerable adults. We confirmed this by checking a sample of staff personnel files.

Good

Is the service effective?

Our findings

People we spoke with were happy with the service provided by the Assessment and Treatment service. One person commented "The level of health care is excellent and this has minimised the number of stays in hospital X has had". People were confident that staff had the skills to meet their relatives' needs.

Nurses at the Assessment and Treatment service were provided with additional training to undertake their role. They were trained to work with Patient Group Directives (PGD) so that if people living at David Lewis developed the early signs of becoming unwell they could use the directive to make an assessment and start early treatment, for example antibiotics. All PGDs were approved by the drugs and therapeutic committee which met quarterly and were then taken to the area prescribing committee.

Staff at the Assessment and Treatment service were constantly looking for ways in which they could improve outcomes for people and were willing to try new techniques. For example, the registered manager told us about one person who had displayed extreme behaviours that challenged staff and other people using the service. They had employed on a temporary contract a behaviour analyst to work with the staff and this person and there had been significant changes to this person's behaviour. This meant they were able to go out of their house and had improved their quality of life. Following this the registered manager told us that they had replaced their challenging behaviour policy and instead developed a positive behavioural support policy and an action plan was being developed to implement it. As part of the development of this policy it had been agreed that a board certified behaviour analyst would be recruited. There are only 220 of these in the UK so a report had been made to outline the case for Tier 2 recruitment, allowing the centre to recruit from overseas.

The provider had policies and procedures to provide guidance for staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (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. 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Because the Assessment and Treatment service did not provide accommodation for people, staff were not directly responsible for ensuring that DoLS had been applied for. However, the details of all applications and information regarding capacity assessments for specific decisions were held electronically. Staff at the service considered and worked within the framework of the MCA in ensuring that any medical or nursing treatment was only carried out following best interest decisions. The social work and safeguarding lead attended all multi-disciplinary meetings held for each individual every six weeks. At these meetings any restrictive practices that had been needed were discussed and staff ensured they were fully recorded as part of people's DoLS plans.

Staff at the Assessment and Treatment service spoke knowledgeably about the need to ensure people consented to their care and treatment and we could see that this was a crucial consideration in the way that they interacted and worked with people. They told us about some of the techniques they used to gain people's cooperation and trust; many of the people they were providing treatment to were unable to verbally consent but staff would ensure plenty of time was available so that each procedure could be talked through and explained. Many of the people they treated had court appointed deputies to act on their behalf. In these instances staff would meet with them to ask how much involvement they wanted.

A system of supervision was in place for all staff working at the Assessment and Treatment unit. Supervision took place 4-6 weekly, each person undertook their supervision with their relevant line manager.

Staff received a wide range of training relevant to the conditions of the people they were providing care to. For example, seven people living at various sites at The David Lewis Centre had percutaneous endoscopic gastrostomies (PEGs) (this is a device which allows people to be fed directly through a tube into their stomach if they are unable to eat normally).

Staff working for the Assessment and Treatment service were also responsible for cascading the training to other staff across the David Lewis site and assessed the competence of staff following training. Training was bespoke and related to specific types of PEG and each individual person who had one fitted.

The clinical physiologist trained staff in identifying the type of seizures people experienced and assessed staff's understanding by reviewing the subsequent records they made where they described the type of seizure. By auditing the records against the person's EEG results she could determine if staff had accurately identified the type of seizure the person had suffered.
All the staff we spoke with said that the training provided was excellent. Staff were encouraged to attend training by external facilitators and to participate in meetings, conferences and events relevant to their role. For example, we spoke with the clinical physiologist and she had attended a national epilepsy meeting and the North West epilepsy meetings and had been supported by the registered provider to present an unusual case study. One staff member we spoke with told us "what they have offered me in terms of training and experience has been huge" and "they took me step by step". Staff told us that the registered provider offered financial support as well as study leave for training. Another staff member told us they had been "blown away" by the level of training provided.

Staff told us that induction training took place over seventeen days and covered all mandatory topics such as health and safety and moving and handling. All the training was delivered face to face and for the last week new staff shadowed existing staff.

Good

Is the service caring?

Our findings

We spoke with a number of staff who without exception, demonstrated a passion and commitment for the work they were doing and a real affection and understanding of the people they were caring for. From the descriptions that staff gave us of how they gained the cooperation and trust of the people they were providing treatment to we could tell that they "went the extra mile" to make sure they felt comfortable and supported. For example several of the staff talked about working flexibly and coming in on their days off so the person they were treating could have their parents with them.

The service had a treatment room and consultation rooms where people were able to be seen and treated in private. Only staff that were actually needed were present in the rooms when people were being attended to. The treatment room had privacy screens around the examination bed and signs were displayed at the door stating treatment was in progress to ensure people's privacy and dignity were maintained.

The registered manager had attended training in end of life care. She had reflected on the training and had identified that due to the complex nature of people's conditions life expectancy was very variable and could not possibly be predicted in the same way as the general population. As a consequence she had worked with the end of life facilitator and bespoke training sessions had been delivered to staff in each house at The David Lewis Centre.

The matron told us that when people went into hospital they always looked to facilitate their early discharge and transfer back to The David Lewis Centre, particularly if it was identified that the person was at the end stages of life. We spoke with several staff about this and they all spoke with great compassion and care about the importance to the person and to staff of continuing to care for them when they had lived at The David Lewis Centre for many years. In one case a person who had been diagnosed as at end of life had returned to the home and continued for several more months to enjoy a good quality of life. This had allowed time for staff to talk with the person, who had very limited verbal communication, but could make their wishes known non- verbally, and they had been able to make sure their wishes for their end of life care were known and when the time came acted on.

The matron told us that because many of the people at The David Lewis Centre had complex needs, Do Not Resuscitate (DNACPR) directives were often deemed appropriate when people were admitted to hospital. When people returned to The David Lewis Centre from hospital doctors at the Assessment and Treatment service would always review someone if a DNACPR directive had been written to ensure that it was still appropriate.

The staff clearly had a very person centred approach to providing health care and treatment to the people using their service and always worked with each person and in their best interests. For example, one person who did not have capacity to consent to medical treatment was very anxious about having blood tests, as they did not like needles. Staff completed a mental capacity assessment and held best interest meetings. When the person was admitted to hospital to have necessary dental work carried out under general anaesthetic, all the relevant paperwork was sent with them and staff were able to ensure that routine bloods

were taken and the flu vaccine administered whilst the person was anaesthetized, to minimise uncomfortable and distressing procedures for the person.

Good

Is the service responsive?

Our findings

People we asked felt the Assessment and Treatment unit was responsive to their relatives' needs and confirmed they were kept informed about incidents and accidents. People attending the clinics were asked to complete feedback forms to record their experience at the clinic. The forms were in a suitable format for people to use. We saw a large number of the forms and the feedback was predominantly either very good or "Brilliant" with just a couple of people commenting on the waiting time to see the dentist.

Staff at the Assessment and Treatment service were responsible for supporting the visiting GPs with annual physical examinations of all the people living at The David Lewis Centre and the nurses held regular clinics to dress wounds, give vaccinations etc. We could see that care and treatment was very person centred and tailored to individual needs. Staff recognised that some of the people living at The David Lewis Centre did not want to come to the clinic and were apprehensive about aspects of treatment, for example needles. They described methods they used to desensitize people from their anxieties, taking small steps with treatment and stopping as soon as the person said they were not happy to continue. In this way they were able to build trust and they found that most people were happy to attend the clinic and could cooperate with the treatments they needed.

Records for each person receiving care were held electronically on the ICare system. Staff at the Assessment and Treatment service also had access to the Evolution medical record system that was shared with the GPs. If someone from one of the houses on site was seen in clinic by a GP, a form was completed which went back to the house with the person, to inform staff at the house what treatment had been carried out or prescribed and staff at the Assessment and Treatment service updated the information on ICare. Staff communicated with each other from one shift to the next with the help of handover sheets with the basic details of who had been seen in clinic and why. More details were available then on Evolution for staff to read and they were made aware of follow up visits that were needed.

Every six weeks multi-disciplinary meetings were held in each house on site for each person living there. Feedback from the meetings was recorded and sent to the matron at the Assessment and Treatment service to update the risk register.

Staff at the Assessment and Treatment service had implemented the National Early Warning Score (NEWS) system to support the on call nurses who were working autonomously in the evenings and at weekends. NEWS had been adapted for the people living at the David Lewis sites to take into account their specific needs and conditions. It enabled the nurses to work through a checklist of points to consider in their assessment of someone and generated a score which would indicate the likely seriousness of the person's health condition.

Individual staff demonstrated an expertise in their field and a real interest and commitment to using this to improve the care and treatment for people using the service. For example, one member of staff had identified that one of the people suffered more seizures when their magnesium levels dropped, so their care plan had been amended to increase the magnesium supplements for the person.

The Assessment and Treatment service adopted the same complaints policy as that in place for the rest of the David Lewis Centre. The complaints log showed a small number of complaints that had been responded to appropriately.

Good

Is the service well-led?

Our findings

We spoke with staff who, without exception described the positive aspects of working at the Assessment and Treatment service. One person had seen staff from The David Lewis Centre out and about in Macclesfield with people that lived at the service and had been so impressed with their attitude and manner towards them that they had rung to see if there were any job vacancies. This person had worked with people with learning disabilities for 25 years and told us the Assessment and Treatment service was the best place she had worked. She said, "Everyone is so open and every professional you need comes on site – communication is brilliant" and "Everyone is so accommodating – everything is all about the individual and their needs."

The registered manager chaired a clinical governance committee which was attended by the medical directors, GPs and representatives from The David Lewis Centre. The committee reviewed all deaths and any reports to coroners. All participants were expected to present a paper each year to the committee, to disseminate learning.

The registered manager told us that she had a monthly supervision session with the Chief Executive Officer.

Staff told us they had monthly team meetings and that the matron and registered manager were both very approachable. Staff told us that the managers involved them in making continuous improvements to the service. For example, it had been identified that dysphagia training would be of benefit so the nurses could make an initial assessment and refer to the speech and language therapists (SALTs) if needed.

We saw a number of examples of ways in which the registered provider was continuously looking to improve the service it provided. For example a red bag system had been developed. This system provided 'red bags' containing specific medicines that it had been predetermined may be needed to treat individuals given their medical history. Delay in starting these medicines when needed could lead to rapid deterioration in the health of an individual and necessitate a hospital admission. The system was developed in response to an understanding that certain people were experiencing quite frequent hospital admissions. In order to try to avoid or reduce unnecessary admissions, clear pathways had been agreed, each for specific individuals so that the nurses working in the centre cover team could instigate treatment at the earliest signs of someone becoming unwell, if symptoms developed outside of normal office hours.

The registered manager told us that the drugs and therapeutic committee met once per quarter and comprised senior clinicians such as the paediatric medical director, pharmacist and matron. Protocols to support the delivery of the red bag system (Patient Group Directives) were reviewed and signed off by this committee and then taken for approval to the area prescribing committee.

The registered manager also sat on the Controlled Drugs Local Intelligence Network (CD LIN) and the registered provider used staff at the Assessment and Treatment service to carry out training, competency checks and audits in medicines management at all the sites at the David Lewis Centre. Where shortfalls in practice were identified these were addressed. For example, it had been identified that the records for the

management of medicines prescribed on an "as required" basis (PRN) was poor at one of the houses on the David Lewis site. Staff from the Assessment and Treatment service immediately went to check the recording systems in all of the other houses on site. Staff were encouraged to report all medicines errors and all were reviewed and classified according to whether any actual adverse effect had been caused or whether the incident was a "near miss". The staff responsible were identified and if repeated errors were highlighted the staff member undertook retraining or had specific supervision to address any practice issues .