Leonard Cheshire Disability

Chiltern House - Care Home Physical Disabilities

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

Chiltern House is situated in the village of Gerrard's Cross in South Buckinghamshire. The location is registered to provide care and support for up to 22 people who have physical disabilities. The home is set out in three separate areas on the ground floor accommodating seven people in two of the areas and eight in the third. Each living area had its own kitchen and dining facilities.

This inspection took place on 13 14 July 2016 and was unannounced.
There was a registered manager in place at the time of our inspection.

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.

People's feedback regarding Chiltern House was mostly positive. One person told us, "I think it is good and the volunteers are a great asset." Other comments were, "To my mind it's excellent, and I feel safe here." A visiting relative told us, "It's first class."

Care plans recorded people's likes and dislikes and provided staff with information to enable them to provide care effectively.

Staff were well trained and motivated and had received training in safeguarding. Staff demonstrated good knowledge of what to do if they suspected someone had been inappropriately treated.

Staff were trained in the administration of medicines and medicines were administered safely in accordance with best practice.

We saw people were cared for with compassion and respect. The registered manager provided effective leadership to the service and held regular meetings with people to ensure they were involved in the running of the home. The service was well-led and people's care was regularly reviewed.

Staff told us they felt happy and supported working for the service. Supervisions took place on a regular basis.

The service had a physiotherapist who worked throughout the week. Activities and social events were planned to give people choice and social contact.

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.

The service deployed sufficient staff to ensure people's needs were met.

Risks were appropriately assessed and staff were provided with guidance on how to manage risks.

Medicines were managed in accordance with best practice.

Is the service effective?

Good

The service was effective.

Staff were well-trained and motivated to effectively support people.

Induction procedures were robust and appropriate for new members of staff.

Staff understood the requirements of the Mental Capacity Act 2005 and people's choices were respected.

Is the service caring?

Good

The service was caring.

Staff were established and many had worked for the service for some time.

People's preferences for end of life care were discussed and the service enabled people to remain in the home as they wished.

Is the service responsive?

Good

The service was responsive.

Regular social events and planned activities meant that people were empowered to make decisions about how they spent their day.

People's care plans were detailed and contained information to enable staff to provide care effectively.

Is the service well-led?

Good

The service was well-led.

The registered manager provided staff with effective leadership and support.

The service worked collaboratively with other professionals

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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.

The inspection took place on 13 and 14 July 2016 and was unannounced. The inspection team consisted of one inspector and a specialist advisor. A specialist advisor is a person who has specific knowledge in a particular area. Their area of expertise was in physiotherapy.

The service was previously inspected on 12 September 2013 when it was found to be fully compliant with the regulations. Prior to the inspection we reviewed notifications we had received. A notification is information about important events which the service is required to tell us by law. We reviewed the Provider Information Record (PIR). A PIR is a form that asks the provider to give some key information about the service what the service does well and any improvements they plan to make.

During the inspection we spoke with six people who used the service, two visiting relatives, six members of the care team, the physiotherapist, the registered manager and the activities co- coordinator.
In addition we observed staff supporting people throughout the home and during the lunchtime meal. We also inspected a range of records which included Medication Administration Records (MAR). We also looked at four staff files, meeting minutes, policies and procedures and monthly audits.

Good

Our findings

People told us they felt safe living in the home. One person told us, "To my mind it's excellent, I feel safe." Another person said, "It's like having a family."

Staff had knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Safeguarding information posters were displayed around the home to ensure people, visitors and relatives had access to information on how to raise issues if necessary.

There were safe medicine administration systems in place and people received their medicines as specified by the GP. We looked at the Medication Administration Records (MAR) and found them to be appropriately signed for and medicines were administered according to the instructions from the GP.

Assessments of need were undertaken prior to people moving into the home. This information enabled staff to formulate a care plan. People's care plans included detailed and informative risk assessments. People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. For example, one person we spoke with told us they were going to the shops to do some window shopping. We were aware the person travelled on public transport to get to their destination. We asked them if they preferred to go alone and they told us, "It gives me some independence and I like my own company". The person's care plan informed staff that the person regularly goes out alone and staff support the person prior to their activity; the person is then independent for the remainder of the day.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. For example, plans were in each person's file on how they were to be evacuated safely in the event of an emergency.

When people had accidents incidents or near misses, these were recorded and monitored to look for developing trends. For example, one person had a previous sacral wound, which had healed, however, staff monitored the person to ensure their clothing was crease free to avoid skin chaffing. We spoke to the person's family member who confirmed this takes place.

People told us there were sufficient staff to meet their needs. The service was committed to involving volunteers to enhance the quality of life for people living in the home and to support the organisation. Recruitment of volunteers was actively encouraged and promoted. All volunteers were checked through the Disclosure and Barring Service (DBS) and received regular support from staff including a volunteer co-ordinator. One person told us "The home have volunteers which is a great asset."

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character which included Disclosure and Barring Service (DBS) checks. Records confirmed that staff were entitled to work in the UK.

Good

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included, "The staff are happy and welcoming to family and friends."
Staff told us they had the training to meet people's needs. Records showed staff had completed a thorough induction which included training in safeguarding, moving and positioning, and disability equality training.

Staff were supported by the registered manager who carried out supervisions and appraisals.
There were regular staff meetings and the minutes of these meetings demonstrated that issues raised by staff had been addressed and resolved. For example, staff had requested guidance on managing diabetes in the home. The management team had requested specific guidance from a professional who visits the service. This had been received and staff were now working within the best practice guidance.

Staff told us they had been supported by the registered manager. One member of staff said, "I have been promoted to team leader and I assist with visits from professionals such as the district nurse and the GP, my manager supports me with this."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent to care and treatment was sought in line with legislation. The registered manager and staff we spoke with had a good understanding of the requirements of the MCA and DoLS. We saw the service had made appropriate referrals to the local authority and the home was waiting to hear the outcome of these applications.

The service followed safe recruitment practices. Staff told us "The induction period is when we complete our

initial training and spend time shadowing an experienced member of staff." One member of staff told us, "My personal feelings are things have improved. I have regular supervisions and have good support from management."

The staff were aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were clearly recorded in their care plans. Menus were created by the catering staff with the support of the dietician and speech and language therapists if required. People told us they liked the food and were able to make choices about what to eat. One person told us, "Food's excellent - you couldn't get better. There are three choices; the chef will get most things within reason, if you don't like what's on the menu.". Care plans contained nutritional assessments and showed people were regularly weighed. In addition staff completed a Malnutrition Universal Screening Tool (MUST). MUST is a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese.

The service worked in partnership with a number of different multi-disciplinary partners including district nurses, GP surgeries and tissue viability and continence nurses. People had a health action plan which described the support they needed to stay healthy. People's changing needs were monitored to make sure their health needs were responded to promptly. This was demonstrated during lunch when we saw one person who required their fluids to be thickened due to their deteriorating health. Staff told us this was a recent requirement, and they had completed training in the use of thickening agents and how to ensure the correct amount of thickener was added in relation to people's requirements.

Good

Our findings

Staff were trained to provide support that respected privacy, dignity independence and human rights. People told us, "Staff treat us with dignity and we all enjoy living so close to the town with its cinema, banks, library and supermarket. We only have to ask and it's arranged as soon as possible for us to go to town."

People told us they liked to leave their bedroom doors open to encourage communication with each other. However, staff were aware that if a door was closed people could be receiving personal care or did not want to be disturbed.

People were actively involved in choosing and deciding on the décor and design within the building. People's bedrooms were personalised and decorated to their taste. We spoke with one person who told us their room had been adapted with an ensuite shower and toilet facilities and easy access to the garden via their bedroom patio door.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People had access to Wi-Fi throughout the building as well as personal tablet computers to aid communication.

People's care was not rushed enabling staff to spend quality time with them. Comments included "Once care is done staff can sit and talk to you."

The home was spacious and allowed people to spend time on their own if they wished. The home had a lounge area, a front sitting room and a conservatory to sit and relax or watch television with others. The home also has extensive grounds for people to enjoy with their friends and family or spend time alone as they wish. Friends and relatives were welcome to visit at any time and were invited to social functions.

People's views were sought through care reviews and annual surveys. People had access to members of the customer support team, personalisation and involvement officers (PIOs), who visited the service on a regular basis. The PIOs supported people to feel confident to self-advocate or to access advocacy services. Information about advocacy services was available to people. We saw information how advocacy services could be accessed throughout the home.

People were given the information and explanations they needed, at times they need them. People and their relatives were given support when making decisions about their preferences for end of life care. Where

appropriate, people were enabled to make end of life plans to ensure that care and support was provided in a person centred way. Liaison with local palliative care and district nursing teams was undertaken where appropriate.

Good

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Staff were able to explain how people preferred to be cared for. For example, people living in the home attended regular physiotherapy sessions. One person we spoke with told us they preferred to have their physiotherapy early in the day before they had their breakfast. Staff confirmed this took place as requested by the person.

People's health needs were reviewed regularly as required. Where necessary health and social care professionals were involved. An example of this was when we spoke with a family member who told us their relatives' wheelchair was in the process of being re-assessed as the sitting position had become uncomfortable and the chair required adjustment.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about changes to medical conditions or care needs and any planned appointments. This meant that staff received up-to-date information about people's needs immediately before the start of their shift. Staff confirmed communication was very good between them.

Where people required support with their personal care they were able to make choices and be as independent as possible. One person told us, "I just need support to 'get ready' and then I am able to go to the shops when I want to." Another person told us they were involved in staff interviews. They told us, "I was involved in interviewing the manager." They went on to say, "It's good for my mental stimulation."

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. The services volunteer co-coordinator had arranged for the local RAF cadets to visit the home on a regular basis to help people in the garden and carry out social activities. The service had a lively activity room where people could cook, use the computer, chat with others or play skittles and board games. Fundraising events such as a summer fayre, Christmas fete and quiz nights took place every year to fundraise money for the service.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. Where people who used the service raised concerns or complaints they were dealt with in a timely manner. The organisation had a national data base that recorded and reported all concerns. There were six complaints in

the last year. Five of the complaints were resolved with one that was ongoing.

Care plans were focussed on the person's whole life and had detailed history of things that were important to them. For example, one person we spoke with enjoyed mental stimulation and attended a creative writing group on a weekly basis. They are also involved in running the activity group.
People were supported to maintain their independence and access the community. People had their needs assessed before they moved to the home. Information was sought from the person, their relatives and other professionals involved in their care. Information from the pre-admission assessment had informed the plan of care.

Good

Our findings

The registered manager was viewed as a role model. Staff told us, "The manager is open to what we say, as a service we are progressing." The registered manager regularly worked alongside staff which gave them an insight into how staff carried out their roles and if any changes or improvements needed to be implemented.

The service promoted a positive culture. This was demonstrated through continued learning for all staff. Additional training was planned to ensure staff were competent to support people with specific needs. We saw evidence that workshops were planned in areas such as blood glucose monitoring of people who used the service with diabetes.

Staff were supported to question practice and those that raised concerns were protected by the service's whistleblowing policy. The service encouraged open and honest communication with people who use the service, staff and other stakeholders.

The registered manager valued staff feedback and acted on their suggestions. We saw minutes of a recent staff meeting, and noted that suggestions were acted upon and put into place. For example, further advice in relation to medication control and diabetes care were sought. We saw that both these areas were discussed with the service's head of quality improvement.

People and those important to them had opportunities to feed back their views about the service and the quality of care they received. Regular meetings were held so that people who used the service could provide input with the running of the home. The service also asked people to assist with interviews and showing visitors around the home. One person told us, "We have regular meetings. If you have any issues we can discuss it then or just knock on the manager's door. They have an open door policy."

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The registered manager had ensured notifications were submitted in line with the regulations.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The manager completed monthly audits of the home. The service was established with a quality-orientated approach and a high degree of quality awareness, which was developed through all levels of staff via appropriate training and leadership of management.