Chilmington Homes Limited

Chilmington House

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

Care service description.
Chilmington House is a care home providing accommodation and personal care support for up to seven people who have a learning disability and sometimes additional physical disabilities. The service is provided in a single story building to promote accessibility.

Rating at last inspection.
At the last inspection, the service was rated Good.

Rating at this inspection.
At this inspection we found the service remained Good.

Why the service is rated good.

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's rights and freedom were protected by staff who also advocated strongly with external services to ensure people's needs were met.

People were kept safe by a staff team who understood how to do this and had attended relevant training. Health and safety and risk assessment systems also helped ensure people and staff were as safe as possible.

Staff were caring, involved people and their representatives in decision making and listened to their wishes. Relationships between people and staff were relaxed, positive and respectful. People's dignity and privacy were promoted by the staff.

The service responded positively and in a timely way where people's needs changed. People had access to a range of appropriate activities and events to reflect their culture, gender and interests.

The views of people and their representatives were listened to and the service took action to address any points raised.

The service was well led by a consistent management team who had effective system to monitor its day-to-day operation and the approach of staff.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Chilmington House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was a comprehensive inspection which took place on 7 and 8 June 2017. The inspection was unannounced on the first day and was carried out by one inspector. We last inspected the service in April 2015, at which time it was rated good.

Before the inspection, the registered manager completed a Provider Information Return (PIR) which we received in March 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help us plan the inspection. Prior to the inspection we reviewed all the current information we held about the service. This included notifications that we received. Notifications are reports of events that the provider is required by law to inform us about. We also reviewed the last inspection report and contacted representatives of local authorities with people they funded in the service, for their feedback.

During the inspection we spoke with the registered manager and four of the care staff. We ate lunch with people in the service on day one and spent other time in the house informally observing interactions between people and the staff supporting them. We spoke briefly to two of the people supported about their experience in the service.

We examined a sample of three care plans and other documents relating to people's care. We looked at a sample of other records to do with the operation of the service, including health and safety certification, recruitment records for two recent recruits and medicines recording.

Good

Is the service safe?

Our findings

People continued to be supported to be as safe as possible. Where risks to individuals were identified, suitable steps had been taken to address them to improve safety, which were not unduly restrictive of people's freedoms. Risk assessments were brought to the attention of staff within handover meetings and signed to confirm they had been read. They were detailed and gave sufficient guidance to staff to enable consistent implementation.

People told us they felt safe and said staff looked after them well. An external care professional told us, "There are no concerns known about this service or the support to our client." No safeguarding incidents had arisen in the previous 12 months. The service had responded appropriately whenever concerns had arisen in the past. Staff received regular updates to training on safeguarding people.

The safety of the environment for people and staff was maximised through regular service and safety checks of equipment and the premises themselves. For example, the fire alarm and detection system was regularly serviced and equipment was subject to weekly checks. An appropriate emergency contingency plan was in place to provide staff with the information and contact numbers needed in the event of a foreseeable emergency arising.

Staffing levels remained sufficient to meet the needs of people within the service and enable them to access the community. Prospective staff were subject to a robust recruitment and checking process and the required records were available to demonstrate this. The service had experienced some recent difficulty with staff recruitment. In the previous 12 months, four staff had left. Some agency staff were used at night. To minimise the impact of this the service requested known staff from the agency, who were already familiar with the service. Recruitment was ongoing for the two current vacant posts. The registered manager had engaged a recruitment agency to assist with finding new staff.

People were unable to manage their own medicines. The service continued to manage these safely on people's behalf. All medicines administering staff had attended training and been competency assessed around the procedure. Only senior and night staff were responsible for administering medicines. The procedure included signing by a second member of staff for each medicine administration and checks of the medicines administration record (MAR) sheets at handovers between shifts. No medicines errors or omissions had occurred in the last 12 months. However, we saw that on one occasion within the current month, a senior had not initialled the MAR sheet for one person's medicines, which they had administered. The registered manager agreed to explore the reason for this omission and remind staff of the importance of accurate recording of medicines. Some prescribed creams in the medicine cabinet had illegible labels, although they were within their use-by dates. The medicines lead staff member agreed to contact the pharmacy to obtain replacements.

Good

Is the service effective?

Our findings

People still received appropriate and effective care and support. The service continued to meet their changing needs flexibly. People told us the staff supported them well and met their needs. An external care professional told us staff were very effective at working on behalf of people, particularly in terms of getting them the healthcare they needed. They wrote that staff had, "…had to push incredibly hard for medical professionals to take their concerns seriously, ultimately resulting in positive outcomes and treatment for my clients." The person had eventually received a clear diagnosis of their condition enabling effective treatment, after the service persisted and obtained a series of medical examinations and tests.

People were supported by a well trained staff team who attended regular updates of core training. The competency of staff was also assessed in key areas such as medicines administration and moving and handling. Staff also received ongoing support and development through regular one to one supervision meetings and annual appraisals to support their development. New staff completed the nationally recognised 'Care Certificate' induction, which included observation of their practice and completion of written workbooks to demonstrate their understanding of all aspects of care. The deputy managers were trained to deliver staff training on the Mental Capacity Act, safeguarding and 'peg' feeding (Feeding via a tube direct into the person's stomach). Staff had access to the local authority's online computer-based training for regular refreshers.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff safeguarded people's rights and freedom. Where people were unable to make decisions about aspects of their care, appropriate capacity assessments had been completed and applications for DoLS made or renewals requested in a timely way. Where decisions about dental or medical treatment had been necessary on people's behalf, this had been done after appropriate best interest discussions involving relevant parties. In one case this led to successful surgery and recovery, supported throughout by staff in the hospital alongside family.

People's routine healthcare was well managed and they had regular check-ups. Where their health impacted on them, appropriate care plans and guidance were provided to staff. For example one person had a detailed epilepsy monitoring plan and a monitor at night-time to enable their wellbeing to be monitored. Another person had a best interest decision in place to address the risk of refusal of essential medicine, because they were unable to understand the potential consequences of this.

People were provided with a varied diet adapted to suit individual needs. Five of the six people supported were at risk of malnutrition or dehydration. Each had risk assessments and guidance in place regarding their needs. The advice of the Speech and Language Therapy team had been sought regarding swallowing issues and dietitians were consulted regarding individual needs. Appropriate guidelines were provided for staff where people required thickened drinks or specifically textured diets. Adapted cutlery and crockery were available where required to encourage independence.

People's day to day comfort had been significantly enhanced because staff had worked effectively with occupational therapy services. They had ensured people who required them, were provided with specially designed chairs and suitable beds to meet their needs relating to their disabilities and posture. The service had also liaised with a reflexologist, known to a person to visit the service to continue their work with them.

The premises had been designed to promote the needs of people with disabilities. The service was all on the ground floor, corridors were wide and handrails provided. Mobile and ceiling hoists and an electric reclining shower chair were provided. Ramps were located at exits to enable ease of access. Sensory aids such as raised beads, had been placed on handrails to warn a blind service user of a partial obstacle on the corridor wall. Doorways were marked with reference objects to identify their use. This enabled the person to have greater independence as they moved to and from their bedroom. The advice of the external 'sensory loss' team had been sought and a folding cane had been obtained for the person's use. The reference objects also helped with orientation for another person who was developing dementia, for whom toilet seats in a contrasting colour, had also been provided. A folding and sliding door had been installed between the dining room and lounge to enable unobstructed access for manoeuvring specialist chairs.

A range of other equipment was provided to help meet people's needs. This included sensory equipment such as tactile activities, light effects and bubble tubes. Individuals had access to such items in their bedrooms for personal use and some equipment was located in the lounge to aid relaxation. Although staff had not attended training on the use of this equipment, the registered manager had previous experience with it and was able to offer guidance on its use.

Good

Is the service caring?

Our findings

The service continued to provide caring support to people. People said staff were kind to them and we saw staff treated people with respect and involved them in daily living decisions. Staff did not stand or talk over people and faced the person with whom they were communicating. We saw warmth and humour in the interactions between people and staff and people were offered prompt reassurance if they were becoming anxious. An external care professional noted, "They are very caring about the clients."

People or their representatives were involved in reviewing people's needs and had been asked about any spiritual needs. None of the people supported at the time of the inspection had identified any, but these had been supported in the past. People were supported to attend external support groups relating to gender or other relevant characteristics. They were enabled to remain in contact with friends from outside the service. Staff had worked with people and their family members to support contact and encourage positive relationships to continue.

The service had worked with people and their families to establish end of life care plans where necessary so that people's wishes were known and could be respected. For example, one person had not wanted repeated hospital admissions as their condition deteriorated. The service liaised with healthcare professionals to enable the person to remain within the service so they were supported by staff they knew and trusted.

People's communication was understood by staff, including their body language. Each person had a detailed individual 'communication passport' describing their preferred communication methods. Their 'passport' described how they expressed their emotions. Tangible choices were offered, such as showing people two options of drinks to select from or offering them the biscuit tin to make their own selection. People were given sufficient time to make decisions and choices for themselves. Care plans noted any known preferences and staff were seen to follow these. For example one person did not like their mouth being wiped while they were eating as this distracted them and could deter them from finishing their meal. The staff member supporting them at lunch followed the care plan and waited until they had finished before doing this to support their dignity. Another person's care plan described how they liked their hair to be cut and this had been done.

People's dignity and privacy were respected by staff. The service had been involved in the local authority 'Dignity Charter' initiative and staff had received dignity training. The service had appointed dignity champions within the staff team to highlight relevant practice issues. The service's dignity charter was periodically reviewed by the team in a staff meeting and a dignity audit was completed in August 2016 with positive results. Written records used appropriate and respectful language and referred to people being involved in day to day decisions.

People's dignity in terms of positive self-image was provided for. For example a manicurist visited during the inspection to attend to the nails of those who wanted this. Staff ensured people's hair was brushed and they were appropriately dressed for the weather and in accordance with any known preferences. People's

clothing was protected at mealtimes by the provision of aprons, which were removed afterwards. Staff knew people's interests and talked with them about these to encourage communication and engagement. Practical provisions such as the ramps at exits enabled people who were not independently mobile to access the garden and take part in social activities there. The provision of adapted cutlery and crockery supported people's dignity by enabling them to maintain their independence.

Good

Is the service responsive?

Our findings

The service had continued to provide a flexible service, responsive to people's changing needs. People were happy their care needs were met and felt they were listened to. An external professional described the service as, "Incredibly responsive, especially to medical issues."

The service and staff were positive advocates for the people supported and sought to ensure they always received the care they needed. In one example of this, the registered manager had advocated on behalf of a person supported by the provider's other community based service, when their needs had changed. This enabled them to move into Chilmington House supported by known staff to provide a smooth transition, whilst maintaining contact with previous friends and professionals. In another example the service worked on a person's behalf to correct overcharging by an external provider. The service liaised very effectively with other external services to ensure people had access to the equipment and support they needed to enhance their lives. External advocacy had also been obtained to support people around decision-making or their health needs.

People were supported by a service which worked very well with external health professionals in pursuit of meeting people's needs. Advice and equipment was obtained and any guidance provided was followed by staff. People's care plans ensured their care needs and wishes were recorded and addressed. Care plans and associated records were detailed and person-centred. They provided staff with the information they needed to provide individualised care. Staff worked to minimise social isolation by supporting people to maintain contact with significant people in their lives through transitions between services and in response to their needs. Where people benefitted from regular and specific routines or ways of working, staff provided this. For example, by using 'Intensive interaction', a technique for developing communication by reflecting and encouraging people's communication face to face. Where people had complex health needs, appropriate guidance was provided to help ensure staff knew how to support them in these areas.

People were encouraged to access a range of community-based services and activities and to enjoy events in the community. When one person had a negative experience with others at a specialist swimming pool, another facility was found so they could continue to enjoy this activity and they were supported through the venue change. People accessed local clubs and groups and were supported to go shopping. Sensory and music therapy sessions were also attended. People ate out with staff and went for walks or were taken out in their wheelchairs.

The service had an appropriate complaints procedure, also available in an easy-read format, although people would still require support to make a complaint. The service's annual quality monitoring report was read to people to seek any feedback they might provide. Complaints forms were available in the entrance hall so relatives or other visitors could obtain one, without having to ask the staff. No complaints had been recorded in the previous 12 months according to the annual complaints review form. A number of positive comments had been made in the same time period. Some compliments were from external health professionals. For example, regarding the effectiveness and competence of staff with regard to 'peg feeding'. A staff member who was leaving recorded positive comments about their experience working for the service.

Relatives had provided positive feedback about the care provided. One wrote having seen their family member's care plan, "It makes me realise how much you do for [name] and how lucky we are that you are there." From the emails seen it was evident positive relationships were maintained with peoples families and they were appropriately kept informed of people's experiences and well-being.

Good

Is the service well-led?

Our findings

The service continues to be well led by the long term registered manager and her senior team. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was a member of the local Care Homes Association which meets regularly to discuss issues relevant to the care industry and local issues. The service works very effectively with external stakeholders, families, health and care professionals in the best interest of the people supported.

The registered manager and other members of the management team monitored care delivery informally on an ongoing basis. They also carried out weekly recorded observations to ensure standards were maintained. Ongoing records of quality issues noted any action required and how this was progressed. Any issues were discussed in supervision or team meetings or noted in the message book. The provider carried out six-monthly quality monitoring visits and provided a report to the registered manager detailed their findings and any necessary actions.

Regular team meetings took place. The minutes showed a diverse range of topics were covered, including people's wellbeing, upcoming events, reviews and reminders about care practice. A team discussion on supporting dignity took place in the April 2017 meeting. A regular newsletter was produced for staff to keep them informed of developments in the service, pensions, legal changes and the achievements of people in the service. Staff were positive and motivated and showed this in the way they went about their work. Staff felt that team spirit and teamwork were good and they were well supported by management.

People would be unable to complete a written survey but their feedback was sought informally on an ongoing basis and staff demonstrated a positive approach to advocacy on people's behalf. The views of relatives and external care and health professionals were sought via surveys resulting in positive feedback. The outcome was fed back to participants via letter, demonstrating the openness of the service. Surveys had been carried out in 2016 and 2017.

The registered manager completed other audits such as an annual medicines audit and maintained records of training, supervision and appraisals to monitor their delivery. A building maintenance plan was in place and an overall service development plan. Maintenance and redecoration was managed by the in-house maintenance person.