The Children's Trust

The Children's Trust - Tadworth

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

About the service
The Children's Trust provides a residential children's home for children and young people with profound and multiple learning disabilities, a residential rehabilitation service for children and young people with acquired brain injury and a Short Breaks service. There are seven houses at The Children's Trust and we inspected Chestnut House.

People's experience of using this service and what we found
Children and young people in Chestnut House were safe and well cared for by committed staff who knew them well.

Staff developed clear, detailed and child-centred care plans from the child or young person's perspective.

Effective systems and processes were in place for safe medicines management. Advice and support from the onsite pharmacist provided good oversight of medication use.

One parent told us what a lovely place Chestnut House was for their child to live and how homely the staff had made their child's bedroom. They said they knew their child was safe and being well looked after.

Why we inspected
CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about.

We undertook this targeted inspection in response to information received which raised concerns about staffing and how children and young people in Chestnut House were being kept safe. The concerns raised suggested care plans were not being followed, that staff were not all properly trained and there was a disproportionately high rate of medicines errors.

We found no evidence during this inspection that people were at risk from these concerns. Please see the safe section of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Children's Trust on our website at www.cqc.org.uk.

We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

This service was safe.

We found that children and young people in Chestnut House were well cared for by caring, committed and competent staff.

We found an open culture with evidence of learning and reflection from incidents and near misses.

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Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on specific concerns raised to us about staffing and how children and young people in Chestnut House were being kept safe. We will assess all of the key questions at the next comprehensive inspection of The Children's Trust.

As part of this inspection we also looked at the infection prevention and control measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak.

Inspection team
This inspection was undertaken by two inspectors.

Service and service type
The Children's Trust is a residential children's home with three houses for children and young people with profound and multiple learning disabilities, and four residential rehabilitation houses for children and young people with acquired brain injury. Chestnut House is home to seven children and young people with the most complex medical needs.

The Children's Trust had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from local authority professionals. We reviewed action plans, investigation reports and meeting minutes provided to us by The Children's Trust.

During the inspection
We spoke with one parent of a young person receiving care at Chestnut House about their experience. We spoke with three members of staff including a clinical educator, house manager and the registered manager. We examined the care records and medicines records of each of the seven children and young people. We looked at staffing rotas and skill mix arrangements. We reviewed staff training and competency records. We looked at how the provider shared learning from incidents with staff.

After the inspection
We continued to seek clarification to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

The purpose of this inspection was to check specific concerns raised to us about staffing and how children and young people in Chestnut House were being kept safe. We will assess all of the key questions at the next comprehensive inspection of The Children's Trust.

Staffing and recruitment

- We did not look at staff recruitment on this targeted inspection. However, on previous inspections no concerns had been identified in this area.
- Children and young people in Chestnut House benefited from being cared for by a wide range of passionate, kind and caring staff.
- Due to the complexities of the children and young people's needs, a system had been introduced where each child had a 'core team' of staff caring for them to ensure their needs were well understood. This had resulted in fewer errors occurring when children were receiving care and treatment.
- We saw evidence of clear and detailed handovers between staff. This meant staff were informed about changes in children and young people's conditions or when amendments were made to their care plans.
- Leaders ensured that the optimal ratio of staff to children was always maintained in Chestnut House, moving staff from other houses when necessary instead of using agency staff.
- We were assured there were robust training and competency frameworks to ensure that staff with the right skills were available to provide safe care and treatment to the children and young people in Chestnut House.
- Staff developed detailed and child-centred care plans from the child or young person's perspective. Care plans were clear and easy to understand. The seven contemporaneous records we reviewed, generally reflected the guidance specified in the care plans. On occasions where this was not the case, appropriate action was taken.

Using medicines safely

- Effective processes had been introduced following medicines administration errors and as a result, the occurance of errors had reduced despite very complex medicine regimes and high numbers of administrations.
- Regular medicines audits were completed and processes were regularly updated to continually strengthen medicine administration in order to reduce the likelihood of errors.
- During a benchmarking exercise using data from the National Reporting and Learning System (NRLS), medicines errors in Chestnut House were found to be comparable with other NHS organisations providing similar complex care.

Preventing and controlling infection

- Children and young people were protected from the risk of acquiring infections in Chestnut House.
- Hygiene standards, infection prevention and control were maintained to a high standard.
- All bedrooms and communal areas were clean. We were assured the provider was meeting shielding and

social distancing rules.
● Personal protective equipment was readily available to staff and all staff were following the latest guidance.
● Children, young people and staff accessed Covid-19 testing.

Learning lessons when things go wrong
● There was an open and transparent culture amongst staff and leaders. Incidents and near misses, including where care plans were not properly adhered to and medicines administration errors occurred, were appropriately identified and reported. Incident reports were detailed, and investigations were thorough with clear analysis and action planning.
● Staff undertook reflective practice with managers to learn from incidents and relevant learning was shared with the wider staff team.
● We saw evidence of changes to systems and processes having a positive impact on the reduction of incidents on Chestnut House.