Anchor Trust

Chalkmead Resource Centre

Inspection report

Deans Road
Merstham
Surrey
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Website: www.anchor.org.uk

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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 was an unannounced inspection that took place on 1, 2 and 4 May 2018.

Chalkmead Resource Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is located in Merstham Village in Surrey.

The home had 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 and associated Regulations about how the service is run.

At the last inspection in January 2017 we looked at the five key questions. The rating for safe, effective, caring and responsive was good with well-led requires improvement. The overall rating was good. We asked the provider to take action to make improvements regarding the registered manager ensuring that all person-centred records followed best practice guidance and the provider reviewed their incident and accident analysis in line with best practice guidance. Both recommendations were followed up and found to be met.

People told us that the home provided a pleasant, friendly and relaxed atmosphere that was created by the staff and they were satisfied with the care and support they received. They also thought there were enough staff who met people's needs in a kind and thoughtful way.

The home's recording, auditing and quality assurance systems were comprehensive and kept up to date. They consistently monitored and assessed the quality of the service provided and information was regularly reviewed and recorded in a clear and easy to understand way.

People had access to community based health professionals when required, staff discussed their health needs with them and they were provided with balanced diets that also met their likes, dislikes and preferences and protected them from nutrition and hydration associated risks.

People told us good quality meals were provided and there was a good variety of choices. Staff supported people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy the experience.

The home was a safe environment for people to live and staff to work in. It was clean, well-furnished and maintained.

Staff knew the people they supported and were appropriately skilled and trained to meet people's needs.

They also understood their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

Staff thought the registered manager and organisation provided good support and there were opportunities for career advancement.

People said they found the registered manager and staff were approachable, responded to them and encouraged feedback from them.

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 remains Good.'

Is the service effective?

Good

'The service remains Good.'

Is the service caring?

Good

'The service remains Good.'

Is the service responsive?

Good

'The service remains Good.'

Is the service well-led?

Good

The service was well led

At the previous inspection recommendations were made that the registered manager ensured that all person-centred records followed best practice guidance and the provider reviewed their incident and accident analysis in line with best practice guidance. We followed up these recommendations and found them to be met.

There were robust systems to assess, monitor and improve the quality of the service people received. People and their relatives were involved in these processes and in the development of the service.

There was a clear vision and positive culture within the home that was focussed on people as individuals. They were enabled to make decisions in an encouraging and inclusive atmosphere. People were familiar with who the registered manager and staff were and encouraged to put their views forward.

Staff were well supported by the registered manager and management team and advancement opportunities were available to them.

Chalkmead Resource Centre

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 an unannounced inspection and took place on 1, 2 and 4 May 2018.

This inspection was carried out by one inspector over three days.

There were 40 people living at the home. We spoke with eight people, 16 staff and the registered manager and other senior organisation's managers within the organisation.

Before the inspection, the provider had not completed a Provider Information Return (PIR) as one had not been requested. 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 also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for six people and four staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People thought the home provided a safe environment to live in and felt confident and comfortable living there. One person told us, "This is a very nice, safe place." Another person said, "I feel safe here, this is my world." The person pointed around the garden.

The home provided enough staff to deliver care to people safely in a calm and relaxed atmosphere that made them feel safe, although some people thought the home could do with a few more as staff worked so hard. The number of staff on duty matched that on the staff rota.

Staff were provided with policies and procedures regarding protecting people from abuse and harm and had received training in them. This was reflected in the care practices that we observed. Staff explained their understanding of what abuse was and the action they would take if they encountered it. Their responses corresponded to the provider's policies and procedures. Staff said that protecting people from harm and abuse was included in their induction and refresher training and a very important part of their jobs.

Staff were provided with safeguarding training and they were aware of how to raise a safeguarding alert and when this was required. The staff handbook also contained safeguarding information. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from.

People's risk assessments enabled them to enjoy their lives safely. They identified areas of risk to people, as individuals, that included all relevant aspects of their lives, specifically health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Relevant information was shared by staff, during shift handovers, staff meetings and when they occurred. Risk assessments were also used as an opportunity for discussion when something had gone wrong so that lessons could be learnt. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and understood.

The building risk assessments were regularly reviewed, updated and comprehensive. The home's equipment was checked and serviced as part of the audit system. There were individual fire evacuation plans for people.

Staff working practices reflected the infection control and controlling the risk of cross infection training they had received and the home carried out infection control checks. The home also minimised the risk of infection by holding a good stock of equipment that included gloves and aprons for giving people personal care.

Staff recruitment procedure was robust and thorough. It was centralised by the provider who advertised internally and externally within the organisation. A job description and person specification was supplied and an application form required to be filled in. Initial screening took place and prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's care philosophy, communication skills and knowledge of the type of care the home provided. If there were gaps in the

knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a three month probationary period. The home had disciplinary policies and procedures that staff confirmed they understood. The home was currently recruiting to vacant posts. One person commented that they had been involved in the recruitment process, at interview stage which was confirmed by the registered manager.

Staff had received training in and understood de-escalation techniques to appropriately deal with situations where people may display behaviour that others could interpret as challenging. These were focussed on people individually and staff had appropriate knowledge to do this successfully. Staff actions were recorded in people's care plans.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. All people's medicine records were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored and the medicine administered recording records (MARR) were audited daily. The drugs were safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

People and their relatives were involved in the decision-making process regarding how and when care and support would be delivered. They told us that staff provided care and support in the way that it was needed and provided it in a friendly, patient and professional way. One person said, "We are treated very well, they [staff] don't shout and we have our own way." Another person told us, "They [staff] sit down and talk to you." Someone else commented, "A warm, friendly home."

Staff spoke to people in an unrushed way so that they could understand what was being said to them. This was carried out in a re-assuring way with staff making contact at eye level and using appropriate body language. People responded positively to this and it enhanced the ability of staff to meet people's needs in a way that they wanted and were comfortable with.

Staff received comprehensive induction and annual mandatory training that included what their roles entailed, their responsibilities, the organisation's expectations of them and the support that staff could expect to receive from the organisation. All aspects of the service and people who use it were covered and new staff shadowed more experienced staff. This increased their knowledge of the home, people and provided quality care. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards' and included dementia awareness, falls awareness, fire training and evacuation, manual handling, first aid, managing people's money and valuables and health and safety. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Staff meetings included an opportunity to identify further training needs. Quarterly supervision sessions and annual appraisals were partly used to identify any gaps in training.

The home had a training matrix that flagged up when training was due to be refreshed.

The equality and diversity training staff received enabled them to treat people equally and fairly whilst recognizing and respecting their differences. This was reflected in staffs' positive care practices and confirmed by people and their relatives. Staff did not talk down to people and they were treated respectfully, equally and as equals. One person told us, "This is home from home and we are all treated the same."

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 people 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).

We checked that 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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised. The provider was complying with the conditions applied to the authorisation. Best interest's meetings were arranged as required. Best interest's meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. During our visit staff frequently checked that people were happy with what they were doing and the activities they had chosen.

There was a policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. Records also demonstrated that staff liaised and worked with relevant community health services especially district nurses, GPs and physiotherapists, making referrals when required and sharing information. This meant there was on-going communication with health care professionals.

People's care plans contained information regarding health, that included nutrition, hydration and diet. Full nutritional assessments were carried out and regularly updated. This was using the MUST tool to assess a person's nutritional status. If required, weight charts were kept and staff monitored how much people had to eat and drink. There was also person specific information regarding any support required at meal times, that included the possibility of choking. Staff had also received training regarding choking and dysphagia. Dysphagia is difficulty or discomfort in swallowing, as a symptom of disease. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. Staff, including the catering team provided nutritional advice. People had annual health checks. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

During lunch we saw people enjoying the experience including those with dementia. There was a lot of laughter, joking and smiling. Staff were supportive, encouraging people to eat meals at their own pace and ensuring people, who needed encouragement to eat, received it. People's needs were met, by staff in a re-assuring and unrushed way. Staff either sat with people to assist them and engage them in conversation or made eye level contact with them by kneeling. This elicited positive responses and body language.

People had their meal choices explained to them and staff explained them as many times as people required to help them understand what they were. They also spent time explaining to people what they were eating during the course of the meal and checked that they had enough to eat.

The meals were of good quality and special diets on health, religious, cultural or other grounds were provided. They were well presented, nutritious, hot and monitored to ensure they were provided at the correct temperature. Staff supported people in a timely way and no one had to wait for their lunch, although the units on which lunch was served were a little cramped for space. Regular meetings took place between people and catering staff to discuss the quality of the meals, how they were served and the type of choices they would like. People said they enjoyed the meals. One person said, "The food is good, I just complimented the chef on the soup, just like grandma's."

The home was clean, reasonably decorated, well-maintained and with no unpleasant odours. The layout was conducive to providing people with a homely atmosphere and suitable communal and personal accommodation. This meant people had the space to socialize as much or as little as they wished.

Good

Is the service caring?

Our findings

The service people received was based on treating them with dignity, respect and compassion. Staff responded to people promptly, were attentive and spoke to them by their preferred name, nickname or title. They knocked on people's bedroom doors and waited for a response before entering and were discreet if people needed to visit the toilet. People told us that staff paid attention to them, acknowledged them and valued their opinions whilst delivering support in a friendly, patient and helpful way. One person said, "You wouldn't get a better place or carers [staff]. They live up to their name, carers." Another person told us, "I can't fault them [staff]."

We saw a number of positive staff care practices and interactions with people that reflected an attitude that went beyond their job descriptions when making sure people's needs were met. One person was concerned that they had lost a purse with some money in it. Staff immediately looked in their room and found it much to the person's relief. Staff were patient, stimulating people skilfully and encouraging them to have conversations with each other as well as staff. They achieved this by applying their knowledge of people, their needs and preferences that enabled them to lead happy and rewarding lives. This was achieved on an individual and team basis. Staff took an interest in people and treated them with kindness and understanding. Their approach to care was supported and underpinned by a knowledge of what people had done in their lives and their families that was built up as relationships between staff and people, particularly using a keyworker system, grew.

There was an advocacy service available that people had access to if required.

There was a confidentiality policy and procedure that staff were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People confirmed that the registered manager, staff and organisation sought their opinions formally and informally. This empowered people to make decisions that staff could then act on. The registered manager and staff took the trouble to make themselves available to people and their visitors. This was if they wished to discuss any problems or just have a chat. The staff made an effort to speedily resolve any issues people might have. This meant people had the opportunity to decide the support they wanted and when and how support was delivered. One person said, "If you need anything, they [staff] get it for you." Another person told us, "They [staff] are so friendly and will help you if you have a problem or there is something you don't understand."

Staff were committed as a team, irrespective of their roles and shared information with each other throughout the home. We sat in on a staff handover where relevant information about people was shared by staff going off shift with those coming on. People were referred to as people, not tasks. This way of working complemented the key worker system and extended to the sharing of people's issues and concerns within the teams.

There was easy to understand written information about the home. This was in sufficient detail to enable people to understand the type of care and support they could expect. It also laid out the home's expectations of them.

The home carried out assessments of people's needs with them and their relatives. If it was initially identified that people's needs could be met, they and their relatives were invited to visit. People could visit as often as they wished to help decide if they wanted to move in and were fully consulted and involved in the decision-making process. These visits were also used to identify if people would fit in with others already living at the home. Some people had first experienced a respite stay at the home, before moving in permanently or had prior knowledge as relatives had used the service. If a service was commissioned by a local authority or the NHS, assessment information was requested from these bodies or from a care home if they had been transferred.

People's assessments provided the basis for their initial care plans. The care plans focussed on people as individuals and were live documents. They included people's interests and were added to with staff when new information became available. The information gave people the opportunity to identify activities they may wish to do. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person. However, the daily notes did not really reflect this, being more task and health focussed and prescriptive of a person's day rather than being balanced with their quality of life.

People's care plans were regularly reviewed, re-assessed with them and updated to meet any needs that had changed. People were encouraged to take ownership of their care plans and contribute to them if they wished. Care plans were underpinned by assessments of risk to people.

The home provided a variety of activities based on people's interests and staff knowledge of people's likes

and dislikes. The activities were regularly reviewed to make sure they were focussed on what people wanted. The success of this approach was reflected in the high participation of people in a singing and ukulele session performed by outside artistes. People were encouraged to join in but not pressurised to do so.

There was a weekly timetable of activities that took into account people's interests and ability to participate. One person said, "We have a good old laugh." Staff reminded people of what was scheduled each day. The activities co-ordinators facilitated a programme of activities with people. These included dog therapy, quizzes, coffee mornings, bingo, poetry, musical entertainment, movie days, senior health and fitness day and a tap dancing day. There was also church services and a hairdresser visited twice a week. One person said, "There is enough to do."

Although the home did not provide end of life care its philosophy was that people could stay until their needs could no longer be met and the home had held a 'dying matters' awareness week. There was specific reference to end of life in people's care plans including guidance and people's wishes. The home supported relatives to make arrangements during a distressing and sensitive period for them. The home liaised with the appropriate community based health teams and organisations such as palliative care and district nurse teams.

People told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew of their duty to enable people to make complaints or raise concerns.

People and their relatives were invited to quarterly home meetings as well as those specific to themselves. The meetings were minuted and people were supported to put their views forward including complaints or concerns. The information was monitored and compared with that previously available to identify that any required changes were made.

Good

Is the service well-led?

Our findings

At the previous inspection recommendations were made that the registered manager ensured that all person-centred records followed best practice guidance and the provider reviewed their incident and accident analysis in line with best practice guidance. We followed up these recommendations and found them to be met.

The registered manager followed an open door philosophy of management. This meant people felt comfortable in approaching them as well as staff. One person told us, "She [registered manager] got things done." Another person said, "Always says hello [registered manager]." Another person told us, "You wouldn't get a better person." People's conversation and body language showed that they were very comfortable with the registered manager and staff.

The organisation had a clear vision and values that staff understood and embraced. The vision and values made clear what people could expect from the organisation, home and staff. Staff said the vision and values were described and explained as part of their induction training and revisited during staff meetings. The management and staff practices reflected the vision and values as they went about their duties. People were also kept up to date with what was going on in the home and organisation.

The home worked in partnership with other agencies, particularly the district nurses who it had a close working relationship with.

Staff had personal development plans and there were opportunities for personal advancement and to develop knowledge and skills. A number of senior posts were filled by staff that had been promoted internally. One staff member told us, "I started as a carer, then became a team leader and am now a deputy." The provider had a development programme that encouraged internal promotion.

Lines of communication and areas of responsibilities were very clear throughout the home and organisation and staff were aware of their specific responsibilities. Staff said they would be comfortable using the whistle-blowing procedure if required.

Currently the home was looking to build and improve links to engage with the local community and a local charity had provided funds for some activities for people.

Staff said they were well supported by the registered manager and management team. They thought that the suggestions they made to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member told us, "They notice your potential here." Another member of staff told us, "We work really well as a team and that includes the [registered] manager."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The quality assurance system contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. There was a district manager's home audit and monthly manager's report that included care plans, medicine, risks, health management, falls, nutrition, health and safety, people's involvement and activities. There were also spot checks and an annual pharmacy review. The registered manager also conducted regular night visit checks. Annual policy and procedure reviews were carried out. Annual surveys were also sent out to people, their relatives and staff.