The Whitgift Foundation

Wilhelmina 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

Overall summary

We visited Wilhelmina House on 30 June and 1 July 2015.

The inspection was unannounced.

The service provides residential care and support to up to 21 people over the age of 65. At the time of our inspection 14 people were using the service but one was in hospital.

The service 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 2008 and associated Regulations about how the service is run.

People at the service felt safe. Staff had completed safeguarding of vulnerable adults training and knew how to recognise and report to abuse. They knew how to escalate concerns. People's needs were assessed and

Summary of findings

appropriate risk assessments developed. There were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. People received their medicines safely and as prescribed.

Staff had the skills, knowledge and experience to deliver safe and effective care and support. People had capacity to make decisions and consent to care and treatment. That capacity was monitored for signs of deterioration. Staff had completed mental capacity and deprivation of liberty safeguards training. People were supported to have a healthy diet and to maintain good health.

People and visitors commented positively about relationships with staff and we observed numerous examples of positive interactions. People and their representatives were supported to express their views and were involved in making decisions about their care and treatment. There were meetings for people and relatives where they could express their views and opinions about the day to day running of the home. Staff respected people's privacy and dignity.

People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. Care plans and associated risk assessments reflected their needs and preferences. People were encouraged to take part in activities that reduced the risks of social isolation. People were confident that they could raise concerns with staff.

Staff spoke positively about the management team and were confident they could raise any concerns or issues. Staff meetings were held on a regular basis. The service had a system of audits and performance monitoring to assess the quality of service they provided.

Summary of findings

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 was safe. People felt safe. Staff understood their responsibilities to protect people from the risk of abuse or harm. There were enough staff to support people's needs. The service provided a safe and comfortable environment. Medicines were administered appropriately.

Good

Is the service effective?
The service was effective. Staff received regular training and management support. People had capacity to make decisions and consent to care and support. Staff were trained in mental capacity and deprivation or liberty safeguards. People were supported with their health and well-being.

Good

Is the service caring?
The service was caring. People commented positively about staff. Staff were aware of their needs and preferences. Staff respected people's privacy and dignity.

Good

Is the service responsive?
People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. People were confident that they could raise concerns with staff.

Good

Is the service well-led?
The service was well-led. Staff spoke positively about the manager. There were appropriate processes to provide feedback and a system of audits, checks and reviews to assess and monitor service provision.

Good

Wilhelmina 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 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 30 June and 1 July 2015 and was unannounced.'

The inspection was carried out by one inspector.

Before the inspection we reviewed information we held about the service which included statutory notifications and safeguarding alerts sent to us by the provider. During the inspection we spoke with three people using the service, three visitors and nine members of staff including the manager. We maintained general observations throughout the inspection. We looked at records about people's care and support which included three care files. We reviewed records about staff, policies and procedures, accidents and incidents, minutes of meetings and service audits. We also reviewed the provider information return that was still being completed at the time of the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe. Relatives and members of staff also said people were safe at the service. One person told us, "I feel very safe here. The staff do look out for us." A relative said, "Yes it is safe. My relative is at risk of falls but often does not wear the falls necklace. Staff do make sure she has it on." A member of staff told us, "I love working with the residents, they are safe and well looked after." Another member of staff said, "Residents are safe, they are well looked after."

We spoke with staff about protecting vulnerable people from abuse. Staff told us they had completed safeguarding training, which we confirmed through staff records and understood the procedures for raising any concerns. Staff were able to explain about the different types of abuse. One member of staff told us how they might recognise signs of possible abuse where people were reluctant to speak about it. The staff told us they would report any concerns to the manager or one of the senior staff and were confident any such matter would be dealt with appropriately. We saw staff were supported with policy and procedures for safeguarding. Before the inspection we checked CQC records and saw the service had sent in appropriate notifications to CQC to meet their statutory obligations. There were systems to protect people from any financial abuse within the service. Any items purchased were accounted for with a receipt. Where appropriate people and their relatives were provided with regular statements on moneys spent with corresponding receipts.

There were significant building works taking place at the time of the inspection. The service had taken appropriate steps to minimise the impact on people using the service and ensured that people, staff and visitors were safe. There were separate entrances to the building site and the service. Appropriate risk assessments had been completed. The building and the rear garden area were pleasant and well maintained despite the building works. People still had access to a large garden area. We saw some minor areas of risk but saw that they were already being addressed by the provider.

We checked the fire safety equipment at the same time as a provider audit was taking place. The equipment was checked regularly and appropriately stored to be accessible in case of a fire. We saw fire alarms were checked once a week. A person using the service told us there had been a recent fire evacuation drill. They said, "I was impressed with the behaviour of the staff, they knew what they were doing. However, all the residents were downstairs – I think we should challenge the residents more." Training records showed that staff had completed fire safety training. The manager showed us a folder of certificates confirming maintenance and checks for essential areas such as legionella disease, gas and electrics. The service had plans in place to deal with foreseeable emergencies.

The service had contingencies to deal with foreseeable emergencies. We were provided with the Business Continuity Plan which provided staff with detailed guidance on action to take in the case of emergency situations; situations that could close or severely disrupt the service. The plan covered situations ranging from civil disobedience to a failure of the gas supply.

We found the service recorded risk assessments that were relevant to the individual and covered a range of social and healthcare needs. People at the service did not have complex needs and were able to self-mobilise to varying degrees and this was reflected in the risk assessments. Risks were identified to staff who were supported to provide safe and appropriate care by the guidance within the risk assessments. The assessments were discussed with people and their relatives (if appropriate) when care plans were developed or reviewed. People using the service had the capacity to be involved and make decisions in relation to their risk assessments. People and relatives we spoke with confirmed they were involved in the process.

There were sufficient numbers of suitable staff to meet people's needs. We looked at staff rotas and staff records. We saw that the rotas matched the staff on duty. Staff said they were happy with the numbers of staff on each shift. On the inspection days there were four staff on duty to provide care that comprised care assistants, senior care assistants and assistant managers. The registered manager, a domestic member of staff, a cook and a kitchen assistant and a member of staff responsible provided further support.

The minimum number of care staff in the daytime was three care assistants one of whom would be a senior or assistant manager. It was evident from the staff rota and what we were told by staff that there were usually four people providing care during the day. During weekdays the manager was usually present as was the activities

Good

Is the service safe?

coordinator. Domestic staff provided weekday and weekend cover. The cook and kitchen assistant had recently transferred to an external company but remained at the service. The domestic and catering staff enabled care staff to concentrate on their caring duties. Planned staff absences as the result of leave, training, accompanying people to appointments and the like were accommodated through the staff rota. Short notice absences or requirement for staff during the day were covered by staff remaining on duty or covering shifts and bank staff. Agency staff were occasionally used to support night staff. The service used only one agency person who had a good knowledge of the service and people using it.

We looked at staff records and policies and found there were robust procedures to ensure only suitable staff were employed. There was a recorded job description, application with an employment history and an interview process. Interview questions and answers were recorded. We noted there were identification documents and two references. Each member of staff had been checked with the Disclosure and Barring Service to ensure they were suitable to be employed in a social care environment.

We saw medicines were managed safely. Medicines, including controlled drugs, were stored safely and securely in an appropriate environment and administered by appropriately trained staff. Support was provided to staff through medicines training, guidance, procedures and policy. We saw there were sufficient medicines available to meet people's needs. There were clear procedures for ordering and returning medicines. We looked at records for the administration of medicines to people using the service. We found there was a list identifying staff initials. There was a yellow front sheet that preceded each person's medicines administration record. It showed the name of the person with a recent photograph and identified any allergies, how people preferred to take their medicines and provided a medication profile. We examined the medicines administration records which were correctly completed. We examined medicines and other relevant records. Room and refrigerator temperatures were monitored and recorded each day. The medicines trolley was neat and uncluttered. Medicines that were not in a blister pack, including pro re nata (as required) medicines, were stored in clearly marked trays for each person. The controlled drugs register and the returns books were up to date. Medicines available tallied with records of medicines administered. People were given the right medicines at the right time.

Good

Is the service effective?

Our findings

People told us they felt staff were suitably qualified and well trained to meet their needs. One person said, "The staff are so pleasant and they know what they are doing. A relative told us, "I cannot think of any of them [staff] that aren't friendly and want to do their best. I think they are very good." One member of staff commented, "We work as a team. The residents are settled and happy." Another member of staff said, "The staff are down to earth and the training is good."

We found staff were supported with supervision meetings and regular training. The supervision meetings took place every three months with their line manager where performance and development was discussed. The provider had a full time trainer who delivered and coordinated training for services in the area. Much of the training and assessment was based in the workplace. New members of staff had a period of induction. We were informed by the trainer that staff who had been recruited with no qualifications in health and social care and staff with no previous experience had completed induction training that met the Common Induction Standards. Any future recruits would complete the Care Certificate as part of their induction to meet recent requirements. Staff competences were monitored and assessed by the trainer or senior care staff. One member of staff said, "I shadowed for a week."

We looked at training records and saw staff training covered a comprehensive range of subject areas relevant to the provision of safe and appropriate care. A training matrix was maintained that clearly showed what training had been completed, what was planned and any staff who had not completed training or refresher training by the due date. One member of staff told us, "There's plenty of training. I'm very happy." Another member of staff said, "There are further training opportunities. We saw that the majority of staff had National Vocational Qualifications Levels 2 and 3 in Health and Social Care (as replaced by the Qualities and Competences Framework).

People told us they consented to their care and support. They were also involved in the assessment of their needs and care planning. People using the service had capacity to make decisions about their care and daily life. Staff had been trained about the Mental Capacity Act, and mental capacity assessments, best interests meetings and deprivation of liberty safeguards. People's mental capacity was regularly monitored for signs of deterioration. The manager told us that should any person develop issues that affected their mental capacity the placement would be reviewed to ensure their needs could be met along with the impact on other people.

People had sufficient food to eat and liquids to drink. One person told us, "The food is quite good but can be a bit boring." They told us Sunday breakfast had been changed in response to requests from the residents. They also commented, "Actually, don't hear many complaints at all." We observed people having lunch. Catering staff plated the food in the dining room and checked the temperature. Care staff served the food to people. There was a pleasant atmosphere, people were not rushed, staff chatted as they served food and encouraged people to eat and drink. People ate at their own pace and were not rushed by staff. People were asked if they wanted more. We spoke briefly with people as they left their tables and they told us they had enjoyed the food. The cook told us there were menu choices and if anybody did not like one of the menu choices an alternative would be provided. There was a rolling menu that was altered on a regular basis. The cook told us that people soon let staff know if they did not like something. Outside of mealtimes fruit, sandwiches, crisps, cakes, microwave meals, tea, coffee and soft drinks were made available. Three people were diabetics but only one required medicines. The cook told us they did not have specific diets but the sugar content in food was reduced or omitted for people with diabetes.

We found people were supported with their healthcare needs. Each person was registered with and seen by the GP at least once a month. People's weights were recorded monthly to identify any unexpected weight gains or losses. We saw evidence of the service reacting to one person's weight loss where the GP was consulted and a referral was made to a nutritionist. We saw multidisciplinary records showing the attendance of other healthcare professionals. People were supported to attend healthcare appointments by a member of staff if a relative was not available. The activities coordinator provided regular fitness and mobility sessions within the activities timetable.

Good

Is the service caring?

Our findings

We spoke with people about their relationships with staff and the care they received. One person told us, "I am quite happy here. I am well treated and the staff are very kind." Another person said,

"The staff have been very supportive." One person commented, "I think the staff here are marvellous." One relative told us, "The activities people are really enthusiastic." Another said,

"My [relative] has been here for years. She loves it, very happy. They always make me very welcome."

Care was delivered by staff in a patient and friendly manner. Throughout the inspection we observed and heard positive and inclusive interactions between people and staff. Although staff were friendly they were also respectful. When speaking with people we saw staff made eye contact. If people were sitting staff either bent down or sat next to them to talk. People were referred to by their preferred form of address which in most cases was their first name. Staff did not rush people to complete tasks, they were encouraged to do things at their own pace. There was a calm and warm atmosphere and we observed pleasantries and good manners from people using the service and staff. We could see from the reactions of people to staff that there was a good relationship. When we spoke with staff they told us they had time to talk with people and enjoyed doing so.

People were assigned a key worker. The key worker was a member of staff who provided people and relatives with a recognised member of staff they could approach with any concerns or problems. Keyworkers attempted to build a relationship with an individual in order to get to know them which involved one to one sessions. They also provided support with more practical aspects of daily living. Keyworkers contributed to care plans, risk assessments and annual reviews. We asked one member of staff about their keyworker role. They were able to tell us about that person's background, their needs and preferences and what sort of things they regularly talked about.

We found people and, where appropriate, relatives were supported to express their views and preferences and to be involved in the planning and delivery of care. One person said, "We do talk about it, my [relative] is asked to come down." One relative told us, "I am involved with the care plan once a year and I am informed of any changes." Another relative told us, "We get an invite every year to update the care plan and they let us know when anything happens." We saw evidence in care plans of people's involvement. Each care plan had a choice form. People's preferences were recorded.

Staff respected people's dignity and privacy and treated people with respect. The service and manager put great emphasis on privacy and dignity in the service which was reflected by most members of staff being dignity champions. Privacy and dignity was also reflected in care planning. We observed that people were clean and well dressed. People's nails were neat and tidy and their hair was clean and brushed. We found there were simple prompts for staff in relation to privacy and dignity. For example, each bedroom door had a notice: 'Please respect my privacy – please knock and wait." We heard and saw staff knock on people's doors. We observed staff clearly explaining to people what they wanted them to do. For example, one person in the lounge was approached by a member of staff who said hello and clearly stated the name of the person. The person responded with a smile. The member of staff asked if they were ready to come into lunch. They then had a friendly conversation as they slowly walked the short distance into the dining room. This simple example was one of many observed during the inspection that showed how people were treated.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. One person told us, "[The activities coordinator] has the patience of a saint, he has wonderful ideas to keep us busy. We do gentle keep fit, he takes us out and there's always something going on." A relative said, "They do listen to me, communication is good. I feel we are working together.

The service carried out a pre-admission assessment for people who wanted to move in. The assessment took place after people visited. No appointments were made for people and families to view the service. They were told to turn up whenever they wanted to. Once the assessment was completed an interim care plan was developed with people and after four to six weeks there was a meeting with the person and relatives to create a more detailed plan of care. (The interim care plans were used for people coming to the service for respite care. We saw that care planning was person centred and focussed on people's needs whilst taking into account their preferences and choices. They also identified personal goals. Care plans and risk assessments were reviewed with people and relatives at least once a year or in response to changes in people's needs. Relatives were kept informed about any incidents or changes.

We found that people using the service benefited from a range of activities that reduced the risk of people feeling isolated, frustrated and bored. In addition to informal activities undertaken by people on their own and with others the activities' coordinators encouraged people to take part in planned activities in the morning and afternoon. We saw a weekly activity timetable that outlined activities Monday to Friday including memory games, tai-chi exercises, shopping trip, bakery and arts and crafts workshops, poetry and story reading. This timetable was flexible and could change at short notice to reflect the weather or what people wanted to do. The weekly timetable was enhance with outings, celebrations and entertainment such as trips to the garden centre, celebrating St George's day, themed celebrations such as a French day and a Dutch afternoon, local school concerts and entertainment by musicians and singers coming into the service. The service has a good relationship with a local school where sixth formers come into the service to join in with activities in the home.

People provided positive comments about the activities. They were encouraged to take part in activities to lead as full and active a life as possible. We were informed by one of the activities coordinators that some people were more inclined to spend time in their rooms. This was addressed through one-to-one activities and 'chats' to prevent feelings of social isolation. Major events were always offered to everyone regardless of their expected response. People using the service had opportunities to make requests and suggestions for activities at residents' meetings or through the residents' representatives. Forthcoming attractions were displayed on notice boards and in the service's newsletter.

The service had systems to learn from people's feedback about their experiences, concerns and complaints. Two people had been chosen to act as representatives of people using the service. One of the representatives told us the service listened to what they said and took action. They mentioned two examples relating to the menu and fire drills. The service held regular meetings with people to keep them informed about what was happening and to listen to peoples' suggestions and feedback. Once a year, people were sent a questionnaire to provide feedback. People attending the service for respite care were asked to complete one at the time.

We saw a summary of the last survey from October 2014 that showed the comments (without identifying people and the manager's responses. It covered areas such as likes and dislikes, how the service could improve, feedback about staff, daily care, comfort and cleanliness, social activities, laundry, catering, health and safety. Overall, the feedback was very positive and where concerns were raised the manager responded on the summary or asked people to come and speak to her in private.

People and relatives told us they would go straight to a member of staff or the manager if they had any concerns. One relative told us, "We are happy, if we had a problem we would have a meeting with [the manager]. She is approachable." We found there had been no recorded complaints since the previous inspection. There was a complaints process that was displayed on a noticeboard in the communal area and was also included in the service user guide

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Good

Is the service well-led?

Our findings

We found that the service was well-led. The manager was appropriately qualified and registered with the Care Quality Commission. We received positive comments about the manager from people using the service, relatives and staff. One person told us, "She is very easy to talk to." A relative told us, "The manager gives me a huge amount of confidence." A member of staff told us, "I get on well with the manager, she is approachable and would take me seriously." Another member of staff said, "The manager is approachable. I feel valued." One member of staff said, "The manager is very supportive, she's fair." The manager told us that she had an open door policy for people, relatives and staff. The manager understood the requirements of duty of candour. The provider had given guidance to the service with a duty of candour policy that supported a culture of openness and transparency.

There were systems to obtain feedback from members of staff and stakeholders. Staff meetings were held every two months and staff also completed an annual survey at the same time as people using the service. We saw minutes of two staff meetings and the summary of the annual staff survey in October 2014. We saw staff contributed in staff meetings and the annual survey was mainly positive. It was notable there were only five responses to the survey from 24 members of staff. This would have been a concern had we received any negative feedback from staff during the inspection but in fact, the opposite applied. Although the responses were mainly positive the low response rate diminished the relevance of the results. There was a better rate of return from the stakeholder's survey and their comments were positive.

Accidents and incidents were recorded along with any initial actions taken and were reviewed by the manager. Further actions were recorded and any lessons that could be learnt, in relation to the individual or the service, were considered. We looked at CQC records and found the service submitted statutory notifications as and when required.

We found there were systems and processes to assess and monitor the quality of service provision. A wide range of audits, visits and checks were undertaken by staff, seniors, the manager and representatives of the provider from outside of the service. The manager explained what took place and at what intervals as stipulated by the provider. We looked at a selection of records covering weekly, monthly and annual checks and audits. For example, medicines were checked daily by staff administering medicines. A senior or assistant manager audited the medicines once a week. The manager checked the audits and also carried out a random check of medicines to ensure the audit was accurate. We saw the manager's monthly health and safety audit for the months of February to June 2015. We also saw two annual audits relating to health and safety that had recently been completed. Any areas of concern were identified and an action plan identified the required response and who was responsible for ensuring it was addressed.

We examined a variety of records relating to the provision of care by the service. Records were accurate, up to date and accessible. Where appropriate, records were stored securely and limited to those people authorised to see them. Records were fit for purpose.