Platinum Care Limited

The White House Care Home

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

This inspection took place on 31 May and 2 June 2016 and was unannounced.

The White House Care Home, known locally as The White House provides care and accommodation for up to 34 people who are living with old age, dementia, mental health issues or physical disabilities. Accommodation is provided over three floors, most rooms are en-suite and there are also shared lounges and dining areas. There are spacious gardens surrounding the building. At the time of the inspection the service was full and there were a number of people with their names on a waiting list.

The White House has a registered manager in post. 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.

We observed consistently positive, warm and caring interactions between people and staff. Staff took the time to stop and chat with people to make them feel involved and to share appropriate humour. Staff knew the people they cared for well and spoke about them with fondness and affection. One staff member said; "I love it here. The people are the best bit". Staff creatively used specialist and personalised communication skills to interact with people and make them feel part of what was happening. The registered manager was committed to sharing best practice and finding innovative ways to promote the rights of those living with dementia.

People's care plans were highly detailed documents which contained information about their background, history, like and dislikes. Staff confirmed that the care plans contained the correct guidance and information in order to support people and provide high quality, personalised care. Life story books had also been developed to help staff to know and understand the people they care for. Staff referred to these and used them to assist them in communicating and engaging with people.

People enjoyed the meals. They told us they were of sufficient quality and quantity and there were alternatives on offer for people to choose from. People were involved in planning the menus and their feedback on the food was sought.

People had their healthcare needs met. For example, people told us they had their medicines as prescribed and on time. People were supported to see a range of healthcare professionals including district nurses, chiropodists, doctors and social workers.

People were kept cognitively and socially engaged through a range of activities, both inside the service and in the local community. There was something on offer each day. People were involved in planning the activities and the atmosphere at the service whilst activities were being undertaken was pleasant and vibrant.

People were kept safe by suitable staffing levels. People told us there were enough staff on duty. This meant that people's needs were met in a timely manner. Interactions between people and staff were unhurried. Staff recruitment practices were safe. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

Staff had sufficient training to carry out their roles effectively. Staff had received training relevant to their role and there was a system in place to remind them when it was due to be renewed or refreshed. Staff were supported by a comprehensive induction and there was an ongoing programme of supervision, competency checks and appraisals.

Staff were knowledgeable about the Mental Capacity Act and how this applied to their role. Where people lacked the capacity to make decisions for themselves, process ensured that their rights were protected. Where people's liberty was restricted in their best interests, the correct legal processes had been followed. People were involved in planning their care and staff sought their consent prior to providing them with assistance.

There was a safeguarding adults policy in place at the service and staff had undergone training on this subject. Staff confidently described how they would recognise and report any signs of abuse, including which external agencies they would contact if required. There were policies in place around the duty of candour and whistleblowing which staff were aware of and applied to their practice. This encouraged an ethos of openness and honesty.

People, staff and relatives were encouraged to give feedback through a variety of forums including team meetings, residents' meetings and questionnaires. This feedback was used to drive improvements within the service. There was a system in place for receiving and managing complaints. People and relatives said they felt confident that if they raised concerns these would be dealt with appropriately. There was an effective quality assurance system in place with a range of audits including, medicines, call bell answering times and staff and resident satisfaction.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse by staff who knew how to identify and report any concerns.

People were supported by staff who were safely recruited.

People were supported by sufficient numbers of staff to meet their needs.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had undergone training in order to carry out their roles effectively.

Staff were supported by an ongoing programme of supervision, competency checks and appraisals to ensure their skills were updated and their learning was continuous.

Staff were knowledgeable about the Mental Capacity Act and how this applied to people they supported. This meant when people lacked capacity to make specific decisions their rights were protected.

People had access to a range of healthcare professionals in order to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with the utmost dignity and kindness. There was a friendly, caring and close bond between people and the staff supporting them.

People were supported by staff who were respectful and ensured their dignity was upheld at all times.

People were supported by staff who knew them very well and who spoke about them with warmth, fondness and affection.

Is the service responsive?

Good

The service was responsive.

There was a system in place for receiving and investigating complaints and people, relatives and staff felt confident that any concerns would be dealt with appropriately.

There were a range of activities on offer in order to keep people socially and cognitively active.

People's care plans were personalised, detailed documents which gave staff the correct level of guidance to provide their care.

Is the service well-led?

Good

People, staff and relatives spoke highly of the registered manager and felt they were approachable and visible within the service.

There were policies in place on whistleblowing and duty of candour and an ethos of openness and honesty was observed from staff.

People and staff were given opportunities to provide feedback on the service and their opinions were valued and used to make changes.

There was an effective quality assurance system in place with a range of regular audits which were used to drive improvements within the service.

The White House Care Home

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 31 May and 2 June 2016 and was unannounced. The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which 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 reviewed notifications about the service. Notifications are specific events registered people have to tells us about by law.

During the inspection we looked around the premises, spoke with nine people who lived at the service and five relatives. We also spoke with eight members of staff. We looked at five care records, three staff recruitment files and a range of policies and procedures. We also observed staff during their medicine round and the lunchtime experience. After the inspection we contacted four health care professionals who had knowledge of the service, to obtain their feedback about the quality of care provided.

Good

Is the service safe?

Our findings

People felt safe living at the service. Comments included; "It's the ambience of the home that makes me feel so safe, everybody seems so relaxed"; "I feel safe because I know the staff know how to look after me" and "The attitude of the staff makes me feel safe. They are so relaxed and happy". One healthcare professional commented that they had no safety concerns.

People were supported by staff who had received training on safeguarding adults. The service had a safeguarding policy in place and posters displayed in prominent places about who to contact if necessary. Staff said they felt confident in recognising and reporting signs of abuse, including which external agencies they should alert if they suspected or witnessed abuse. One staff member said "If I suspected anything I would go straight to the manager, I wouldn't think twice about that".

People were supported by staff who understood and managed risk effectively. People moved around the home freely and were enabled to take every day risks. The ethos of the home written in the statement of purpose was to "promote ordinary life" and this was evident throughout the inspection as people accessed different parts of the building and gardens as they pleased. People had PEPS (personal evacuation plans) in place to provide guidance on what support they would need should an evacuation be required.

Accident and incidents were recorded by the registered manager and then audited by the senior management team to look for any recurrent themes. For example, there had been an audit on the number of times a person had fallen and this had been incorporated into their care plan and risk assessment alongside steps to reduce the risk.

People were supported by staff who were recruited safely. Employment checks were completed before new employees began working. For example, Disclosure and barring service (DBS) checks and references were obtained. This helped ensure the staff had the right qualities to work in the care sector.

People were kept safe from the risk of cross infection by a clean environment. The home was visibly clean, with hand sanitising gel, gloves and aprons throughout the building which we saw staff using throughout the inspection. There was a laundry room staffed by a separate team with washing and drying machines and staff used colour coded baskets for laundry to prevent cross infection. Cleaning rotas were evident throughout the home and there were infection control audits overseen by the operations manager. Anything identified as an area for improvement on the audit was promptly addressed. There were contracts in place for the disposal of domestic and clinical waste.

Care plans and risk assessments contained information on how to support people if they became distressed or agitated. For example, one care plan contained information about things the person enjoyed talking about and subjects for staff to discuss to help them to remain calm. One staff member said; "If people become agitated we use distraction to settle them. Knowing the person is what helps you to manage the situation".

There were sufficient numbers on duty to meet people's needs safely. We observed staff responding to people's needs in a timely manner and having opportunities to interact with them in a way that was unhurried. One staff member said; "There are enough staff to keep people safe. We pull together as a team". The service also operated a volunteer scheme with volunteers having extra time to meet people's social needs, such as taking time to chat to them or enable them to help in the garden. There was a stable staff team, some of whom had been in post for many years. This helped to keep people safe as it provided continuity of care.

People's medicines were stored, administered and disposed of safely and staff had undergone training to administer medicines. People told us they had their medicines as prescribed and on time. Medicine administration records (MAR) had been signed and updated to ensure medicines were correctly administered. Where refrigeration was required, this fell within the correct temperature guidelines. There had recently been a pharmacy visit to look at medicines management which found that practices were safe. People's medicines were reviewed by their doctor annually or at any time at the person's request.

Good

Is the service effective?

Our findings

Staff said they had received sufficient training to carry out their role effectively. One staff member said; "One of the best things is the training. There is always more training available on anything you request". The registered manager had a system in place to ensure staff were trained in all areas identified by the provider as being mandatory and to remind them when training was due to be renewed or refreshed. Staff had requested additional training in specific areas relating to their roles such as dementia and catheter care. One staff member told us that they had attended training on using sign language to accommodate the needs of a person living at the service.

New staff underwent a thorough induction process which incorporated the Care Certificate. The Care Certificate has been introduced to train all staff new to care to a nationally agreed level. Three existing staff members were becoming assessors for the Care Certificate to help new staff to gain the qualification. New staff shadowed more experienced staff and did not lone work until they had completed their induction. During the induction, staff familiarised themselves with the statement of purpose and the visions and values of the home, including their vision of promoting ordinary life. Staff were aware of this and it was evidenced in their work with people. Staff had their own development plans and ongoing learning was encouraged. There was ongoing regular supervision for staff on a one to one basis as well as an annual appraisal. One staff member said "I've just had my appraisal. It's nice to see growth and how far you have come".

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive possible. If a person lacked capacity their care was discussed with a range of professionals and family, where appropriate, to ensure the decisions were made in the person's best interest. People had decision specific mental capacity assessments on their files where it was required and staff we spoke to had a good understanding of the principles of the Act and how this applied to the people they supported.

People can only be deprived of their liberty in order to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had sought authorisations under DoLS when they were required and the documentation was stored in their files alongside information on what this meant for the person being supported.

People's consent was clearly obtained by staff prior to them undertaking a task, for example, we saw staff asking people how they wanted to have their medicines and also seeking permission before entering their bedroom. One staff member said; "We seek consent before anything we do".

People had their nutritional and hydration needs met. The service operated a "traffic light care plan" for the

level of support people required with their meals. This categorised people in terms of their level of risk and need with eating. Hot and cold drinks were available for people throughout the day. We observed people having their lunch. People either chose to eat in one of the dining rooms or in their bedrooms. The atmosphere during lunch was pleasant and relaxed. Tables were laid with table cloths and flowers and people were offered a range of drinks with their meals, including alcoholic beverages if they wished. People enjoyed the meals. Comments included; "I have my meal in my room and it's always hot when they bring it"; The food is absolutely brilliant"; "The meals are better than what you get in top class hotels" and "The choice of food is good, there's always something different". People were offered a choice of two hot meals, with lighter alternatives available. Homemade cakes, biscuits and soup were prepared daily. One relative said "You can't improve the food". People were involved in planning the menus at the residents' meetings and were able to request meals to be added to the monthly menu plan. Safe practice advice sheets were displayed in the dining rooms with advice for staff such as encouraging people to feed themselves and allowing them to rest mid-meal. Referrals were made to SALT(speech and language therapists) or dieticians as required. Special dietary requirements were catered for, for example people with diabetes were able to enjoy the same puddings as others as diabetic custards, jams and sugar substitutes were used. A daily menu was printed off and displayed in the entrance hall which provided information around the meals on offer, for example if they contained gluten.

People had their healthcare needs met. Records indicated they saw a range of health and social care professionals including GPs, chiropodists, speech and language therapists and dentists, as required and staff supported people to attend appointments where necessary. Records also indicated when the person had last had their flu vaccinations or had a dental examination and this prompted staff to help them keep up to date with these. There was a section in their records for external professionals to write their notes and this was up-to-date and comprehensive. One external health care professional said; "They are good at monitoring people's mental health and keeping us informed about any changes to it". At the time of the inspection a dentist was attending the service to carry out routine dental examinations. One relative we spoke with said their parent had needed to see a doctor as they had experienced breathing problems and that this was quickly arranged by staff.

People's bedrooms were personalised and they were able to choose how they were decorated. People had selected the colour of their bedroom door which helped them to orientate themselves within the home. There was a lift and stair lift which were used to enable people to access different parts of the building. Corridors were wide enough for wheelchairs and other equipment and fitted with handrails. There were spacious gardens with seating, a vegetable patch, flower beds and bird tables which people were enjoying. There was a parasol which people were sitting under during our visit and there was a pile of sunhats in the entrance porch which people could help themselves to when going into the gardens.

Good

Is the service caring?

Our findings

People and relatives were consistently positive about the caring nature of staff. Comments from people included; "There is always someone to put an arm around your shoulder"; "The staff have been good to me from day one" and "There is just nowhere better, the staff are brilliant". One relative said; "The staff are as good as gold, always willing to help".

Staff treated people with the utmost kindness, spoke with them in a warm, caring and compassionate manner and used appropriate humour in their interactions. Staff used their in depth knowledge of people creatively to help ensure they felt cared for and included at all times. We observed a staff member using sign language to interact with someone and involve them in what was going on. This had a particularly positive impact on the person and they opened up and began to communicate. Another person could become distressed when using the moving and handling hoist and staff found that if they sang to them it alleviated their distress. We observed staff singing with this person and the positive response it created.

The atmosphere in the home was upbeat and vibrant. People were smiling and told us they enjoyed living there. Comments from people included; "The staff are full of fun and happy" and "The staff are always so cheerful and happy". If people needed to go to hospital staff stayed in touch with them and visited them. One person, who had just returned from hospital, said "I couldn't wait to get back here". One external healthcare professional said; "It's a really nice home with a homely feeling. It feels like someone's home rather than a care setting".

People were treated with respect and their dignity was protected. We frequently saw staff knock and wait to be invited to enter before going into people's bedrooms. Offers of care were made sensitively and discreetly. One staff member said; "When providing personal care, we use towels to cover people, explain what we are doing step by step. We think about how we would want to be treated, or our parents". People were given a choice of who provided their personal care and whether they preferred a male or female member of care staff. The registered manager and a senior member of staff were Dignity Champions. A Dignity Champion is someone who believes passionately that being treated with dignity is a basic human right. Dignity Champions pledge to challenge poor care and act as role models to campaign, inform and educate those around them. This was reflected in the caring and respectful attitude of the registered manager.

The registered manager was passionate about the needs of people living with dementia. They were involved in setting up of Bodmin as a "Dementia Friendly Town" and attended regular meetings around this. The service participated in a Dementia Awareness Day locally. This evidenced the service's commitment to promoting the rights of those living with dementia.

People were supported to express their views through a variety of forums including residents' meetings. People were also actively involved in decisions about their care and involved in developing and reviewing their care plans. Advocacy services were used when required, to support people who were unable to do this independently to help ensure their views were heard. One person didn't have anyone who visited them regularly and with their consent, a referral had been made for a befriender or visitor in response.

People's independence was promoted through involvement with day to day tasks. For example, people assisted with laying the tables, bringing in the washing or gardening. A vegetable patch had just been created and people were encouraged to help with tending to it. One staff member said; "We promote independence with personal care and provide encouragement. People help with things like planting flowers, making pizzas and helping with the barbeque".

Staff knew the people they cared for well, including their background, history and likes and dislikes. Comments from staff included; "I love finding out about their history through chatting. It helps you see the person in a different way" and "I like to listen to people and to communicate. I learn about them and it helps to build trust". Care records reminded staff to do something nice for people at the end of care interventions if they had become anxious, such as sit and talk to them or make them coffee.

People were made to feel important by staff's attention to detail. Care records were very detailed and included information such as how strong a person liked their tea or whether they preferred it in a mug or cup and saucer. There were also details about whether they liked a light on in their room at night, or a drink on their bedside table. During handovers people's mood was discussed to ensure their well being was maintained. For example, staff had noticed that one person seemed a little low in mood and they were discussing things they could do to make them feel better. People's religious and spiritual needs were discussed in their care plans and there were regular visits from church ministers to the service.

People told us they were made to feel special. A cake was always baked for them and they were given cards and presents on their birthday. Relatives were also made to feel welcome. One relative said "It's like an extension of your own family". Staff confirmed "We make visitors feel welcome, give them refreshments, chat to them". People benefitted from a volunteer scheme operated by the service. Volunteers told us they were able to provide that extra one to one and support for people, and could dedicate time to chatting with people and helping them in activities such as gardening.

When people moved into the service, they were supported by staff members who were aware of any anxieties people might have and acted to reassure them. One staff member said; "When somebody new comes in, I try to imagine how I would feel coming into a new place. I try to be approachable, use a nice tone, introduce myself, show them around. It must be scary but it's so nice to see them start to feel comfortable and to come and interact".

The home was committed to providing excellent end of life care. Staff had received training in end of life care and worked closely with other professionals such as dementia liaison nurses to develop end of life care plans . Families and other professionals were involved in updating these plans. One volunteer spoke of their admiration of the care staff in their approach to people nearing the end of their life.

Good

Is the service responsive?

Our findings

People had access to a range of activities in order to keep them socially and cognitively engaged. There was a diverse range of options available such as movie nights and quiz nights, Pilates, manicure sessions and visits from petting animals. There were also regular trips out such as picnics in the woods, train rides and cream teas at local cafes. There was something on offer every day and people were involved in planning the activities by being asked for suggestions at the residents' meetings. One external health care professional said; "The activities are very good. There is always a lot on offer and they get families involved in the activities too". Staff were in the process of planning with the male residents, some activities that would be specific to them as they had noticed that more of the options were more suitable for the females. A number of suggestions had been put forward and staff were making arrangements to implement them. People were encouraged to go to local meeting groups such as the Memory Café and Age Concern.

People were supported to maintain relationships with people that mattered to them. There were no restrictions on visiting times and relatives came and took people on outings. One person was going out with their family for fish and chips and another was going to spend the day at a relative's house. Staff made arrangements to support people on their trips out with relatives, such as preparing their medicines and ensuring they had any personal belongings with them that they might require.

There was a process in place for receiving, investigating and managing complaints, supported by a policy. People and relatives said they felt confident to raise a complaint and felt that it would be dealt with to their satisfaction. If concerns had been raised, they were dealt with in a timely manner, an apology had been made and plans had been put in place to make improvements in future. People were encouraged to express their views. Whilst we were carrying out the inspection the registered manager was proactive in explaining who we were and making all visitors aware they could speak with us.

Call bells were answered promptly. There had been a concern raised by a person in relation to this and as a response, the registered manager had implemented equipment which recorded all calls and answering times. This was audited and as a result there was a re-organisation of how staff were deployed. This had been successful and call bells were now answered within the target time set by the service.

Prior to coming to live at the service, a thorough assessment was undertaken of a person's needs covering areas such as capacity and consent, DoLS, diagnosis, diet and equipment as well as an assessment of their interests and hobbies. People and their families were invited to come and look around to ensure it was the right place for them. Appointments such as hearing, optician and dental check ups were arranged if the person required them.

There were comprehensive handover meetings up to four times per day in which people's changing needs were discussed alongside how staff should respond to them. At one meeting, staff discussed how one person was awaiting a visit from a dentist and needed a soft diet. Another person had been feeling unwell and staff discussed ways of helping them, such as prompting with extra fluids and encouraging them to keep active.

People's care records were personalised documents which guided staff on how to meet their needs. For example, one person lacked motivation to attend to their personal care, but responded well to a jovial manner from staff. The care plan contained detailed information about the approach and manner staff should use. Care plans also contained information on social needs. One person had become socially isolated prior to coming to live at the service and the care plan contained detailed information on how staff should work to address this and to help the person to re-engage. One member of staff said; "The care plans are good and regularly updated. They give us the guidance we need". People had life story books in their rooms. One staff member said; "We have life-story books and it can be great to sit and discuss these with a person".

Consistent with information from the PIR, we observed the telehealth system. This had been implemented at the service so that people's needs could be monitored and any changes responded to quickly. For example, people's weekly weights were inputted which were then assessed meaning that if there was a risk of malnutrition it would be quickly identified and staff could act promptly to intervene.

Good

Is the service well-led?

Our findings

People, staff and relatives felt the service was well led. Staff said the registered manager was approachable and visible within the service. One staff member said; "[…] is very approachable. You can go and give feedback and if you have concerns they are sorted straight away".

People and relatives told us they would be confident to raise a concern with the registered manager and that it would be dealt with. One relative said; "I don't have any cause to, but I would absolutely feel comfortable to raise a concern if needed".

Staff were asked for their opinion on the service and any suggestions were listened to. During one staff meeting there had been a discussion about call bells and how they could be answered more promptly. Staff had given suggestions which had been put in place and this had resolved the issue. Staff valued the team meetings and said they were an opportunity to share ideas as well as any concerns. People were also given opportunities to share their ideas on the service. There were regular residents' meetings and feedback was sought on subjects such as activities, days out and menu plans.

There were clear lines of accountability within the management structure and the registered manager was supported in their role by a senior management team, who were also visible within the service.

The service had an ethos, which was written in their statement of purpose and displayed in the reception area. The ethos was "Commitment to the promotion of ordinary life". When asked, staff were aware of this and said it reflected how they worked.

The registered manager knew how and when to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. They also kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and honesty. The registered manager had a policy in place on the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The registered manager also had a policy in place on whistleblowing, which staff were knowledgeable about. The policy supported staff to question practice. Staff confirmed they felt confident to raise any concerns with the registered manager or to go further up the management hierarchy and that they would be dealt with appropriately. One staff member said; "I would always speak out or I'd be as bad as whoever was doing something wrong".

The registered manager attended a number of forums such as the Outstanding Managers Network, a meeting attended by managers to share good practice and ideas. This was then applied to the service to raise standards.

Staff were happy in their work, understood what was expected of them and were motivated to provide a high standard of care. Comments included; "I love it here"; "I wouldn't want to work anywhere else"; "It's a

happy place"; "I think the team and the care are outstanding" and "The best thing about being here is making a difference in people's lives".

The registered manager operated an effective quality assurance system. Questionnaires were sent to people and relatives annually in order to gain their feedback on the service and to make changes if required. There were a range of audits in place such as medicines, accidents, falls and cross infection to raise standards and drive continuous improvement. There were regular checks to ensure the building and equipment were safely maintained. The utilities were also checked to ensure they were safe.