Care UK Community Partnerships Ltd

Whitefarm Lodge

Inspection report

Vicarage Road
Whitton
Twickenham
Middlesex
TW2 7BY

Tel: 02087555740
Website: www.whitefarmlodgetwickenham.co.uk

Date of inspection visit:
30 October 2017
06 November 2017

Date of publication:
18 December 2017

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 30 October and 6 November 2017.

White Farm Lodge is a care home providing care and support for up to 60 older people, who may have dementia. The service is located in the Hampton area of west London.

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 November 2015 all the key questions of safe, effective, caring, responsive and well-led were rated good and there was an overall rating of good.

People, their relatives and staff said that the home was a nice safe place to live and work in. Staff respectfully delivered good care and support in a way that people enjoyed and enabled people to do the things they wanted to and join in the activities provided if they wished.

The home provided a warm and friendly atmosphere with visitors made welcome. The home was well-maintained and clean.

People's and the home's records were kept up to date with clearly recorded, fully completed, and regularly reviewed information. This enabled staff to perform their duties appropriately.

Staff knew the people they provided a service for well and this included their likes, dislikes, routines and preferences. During our visit people received the same attentive service and everyone was treated equally with staff performing their duties in a kind and caring way. Staff had appropriate skills, qualifications and were focussed on providing individualised care and support in a professional, friendly and compassionate manner. Whilst being professional they made themselves accessible to people and their relatives in a friendly, approachable way.

Staff said they had access to good training, support and career advancement.

People were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. They said the choice of meals and quality of the food provided was very good. People were encouraged to discuss health needs with staff and had access to community based health care professionals, if they required them. People were prompted to eat their meals and drink at their own pace.

The home's management team was approachable, responsive, encouraged feedback from people and their relatives and consistently monitored and assessed the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Whitefarm Lodge

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 that took place on 30 October and 6 November 2017.

The inspection was carried out by one inspector over two days.

There were 52 people living at the home. We spoke with eight people, five relatives, 14 staff, and the registered manager and three health professionals who had knowledge of the service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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, were shown around the home and checked records, policies and procedures. These included the 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 and their relatives said that staff provided care and support in a safe way and in a safe environment. One person said, "It is very safe here and I'm very happy." A relative commented, "Definitely a safe environment, [Relative's] brother was here before and we have been associated with the home for a long time."

Staff had been provided with safeguarding training, were aware of when a safeguarding alert was required and how to raise one. There was also safeguarding information provided in the staff handbook. There were no current safeguarding alerts and previous safeguarding concerns had been appropriately reported, investigated, recorded and learnt from.

Staff were trained and understood what constituted abuse and the action to take if encountered. The home had policies and procedures regarding protecting people from harm and abuse and staff confirmed that they were familiar with them. They said that protecting people from harm and abuse was one of the most important of their duties. There were leaflets and information describing what abuse was and how to report concerns throughout the home.

People's care plans contained risk assessments that enabled them to enjoy their lives safely. The assessments identified areas of risk relevant to people as individuals including their health, daily living and social activities. The risks were colour coded denoting different levels of risk. The risk assessments were regularly reviewed and updated when people's needs and interests changed. Staff shared relevant information, including any risks to people during shift handovers, staff meetings and when they occurred. The home also kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and knew how to use.

The home had building and equipment risk assessments that were reviewed and regularly updated. The home's equipment was regularly checked and serviced. The home was clean, well-maintained and each floor had hand-wash and sanitisers for people to use. Staff had also received infection control training and their working practices reflected this with them washing their hands at frequent intervals.

There was a thorough staff recruitment procedure that recorded all stages of the process. The organisation's HR department undertook staff recruitment and the home also held recruitment open days. The recruitment process included advertising the post, providing an application form, job description and person specification. Prospective staff were short-listed for interview. The interview was conducted by the home's registered manager. It contained scenario based questions to identify people's communication skills and knowledge of the field in which they would be working. References were taken up and Disclosure and Barring Services (DBS) security checks carried out, prior to staff starting in post. In the case of nurses employed their registration was checked to make sure it was up to date. Work history was checked and an explanation required for any gaps in it. There was a three monthly probationary for care and other staff and a six month probationary period for nursing staff with regular reviews. The home had disciplinary policies and procedures that staff confirmed they understood.

During our visit there were enough staff to meet people's needs and support them to do as they wished with staff being attentive, reassuring and supporting people to move around the home safely. The staff rota showed that support was flexible to meet people's needs and there were suitable arrangements for cover in the absence of staff due to annual leave or sickness. This was through permanent staff being offered extra shifts and the use of bank and agency staff. The registered manager said that whenever possible the same agency staff were used as they were familiar with people, their likes, dislikes and routines. One person said, "Plenty of staff."

Staff had received training in de-escalation techniques where people may display behaviour that others could interpret as challenging. This was put into practice with staff using different techniques to calm people that were recorded in their care plans.

Medicine was safely administered to people and the nursing staff who administered medicine were appropriately trained and qualified to do so with regular refresher training. They also had access to updated guidance. The medicine records for people were checked and found to be completed 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 specific controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited weekly. The drugs were safely stored in a locked facility, records of the temperature of fridges where medicine was stored were kept and medicine was appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

During the inspection people made decisions about their care and what they wanted to do. Their level of involvement in decision-making varied depending on people's capacity to do so, although staff made every effort to facilitate people to make decisions. People on the residential floor were fully engaged in making decisions about their lives, whereas people on the nursing floor with less capacity, due to dementia or illness where supported to make decisions on a more basic level, appropriate to them. In all instances relatives or people's representatives were encouraged to be involved in the decision-making process with staff sharing relevant information with them.

People and their relatives said staff provided a relaxed, comfortable atmosphere that people enjoyed and the type of care and support that was what was needed. Staff delivered support in a friendly, enabling and appropriate way that people liked. One person said, "I can't complain about anything and would be telling a lie if I did." Another person told us, "I'm very happy, everything is going great." A relative said, "An excellent place that I would recommend."

Staff received induction and annual mandatory training and a staff handbook. The induction training was comprehensive and included core training and information about staff roles and responsibilities. It also outlined the home's expectations of staff and the support they could expect to receive. All aspects of the service and people who use it were covered. New staff shadowed more experienced staff to gain knowledge about how the home ran and people living there. There was a training matrix that identified when mandatory training was due. Training encompassed the 'Care Certificate Common Standards' and included infection control, manual handling, medicine, managing challenging behaviour, equality and diversity and health and safety. There was also access to more specialist training to meet people's individual needs, such as dementia, pressure ulcer awareness and end of life care. Monthly staff meetings included opportunities to identify further training needs. Bi-monthly supervision sessions and annual appraisals were also partly used to identify further training requirements.

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 they 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 if 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, all applications under the DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests

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 the 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. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit.

The care plans included sections for health, nutrition and diet and staff had received nutrition and food hygiene training. Full nutritional assessments were undertaken and regularly updated. Weight charts and hydration records were kept if required and staff monitored how much people had to eat. The care plans also contained information regarding any support required at meal times. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP if appropriate. Nutritional advice and guidance was provided by staff and there were regular visits by community based health care professionals. People had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

People told us they thought the food was very good with plenty of variety and choice. One person said, "The food is good, bed warm, what more do you want when you are a hundred." A relative told us, "They spoil [Relative]. They make sure [Relative] eats and I'm well satisfied." Staff communicated well with people, understood their roles and the way people required support. Examples of this were on the nursing floor at lunchtime where staff took time to explain to people the choice of meals, what they were eating and enabling them to eat at their own pace. This enhanced the meal as a pleasurable experience with staff chatting to people and making sure they were enjoying it. Staff were seated and faced people at eye contact level when engaging them to re-assure and support them appropriately.

Staff had received equality training that enabled them to treat everyone equally and fairly whilst recognizing people's differences. This was reflected by the positive staff care practices we saw during mealtimes and at other times throughout the visit.

Good

Is the service caring?

Our findings

People felt that staff knew them, their needs and preferences well and were therefore in a position to meet them. People and their relatives spoke positively about the caring way staff provided support. They said that staff tried hard to provide a comfortable, relaxed and enabling atmosphere for them and were committed to their care. One person said, "They [Staff] are great here." Another person told us, "Excellent staff, top rated." A relative said, "I cannot fault the staff in anyway and so pleased [Relative] is living at White Farm Lodge."

People told us that staff respected their privacy and dignity, knocking on their doors before entering, addressing them in the way they preferred and enabling them to maintain their independence as much as possible. People enjoyed living at the home and were supported to do the things they wanted to. They were encouraged to join in activities if they wished but not pressurised to do so. Staff also made sure people were involved and encouraged to do things for themselves, where possible. They facilitated good, positive interaction between people and promoted their respect for each other. Staff were friendly, helpful, listened to people and acted upon what they had to say. Positive care practices were underpinned by the training that staff had received. Staff knew the people they were caring for, called them by their name and interacted with them in a friendly and appropriately familiar way.

Staff were able to tell us information about people, such as if they had dementia and how advanced it was, people's preferred method of communication and engagement, and their likes and dislikes. Staff were skilled and caring in the way they provided support and made an effort and encouraged people to enjoy their lives. Staff spoke to people in a way and at a speed that people could comfortably understand and follow. If people had communication issues, staff were aware of people's individual preferences for using single words, short sentences and gestures to get their meaning across. Staff spent time engaging with people, talking in a supportive and reassuring way and projecting positive body language that people returned.

The home provided end of life care that staff had received training in and there was specific reference to this in people's care plans including guidance and people's wishes.

The home also had a confidentiality policy and procedure that staff were aware of, understood and followed. Confidentiality was included in induction, on going training and contained in the staff handbook.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. People said they had visitors whenever they wished, and they were always made welcome and treated with courtesy. This was also the case when we visited.

Good

Is the service responsive?

Our findings

The home's registered manager and staff asked people and their relatives for their views and opinions. They were given the opportunity to decide the support they wanted and when. This was delivered in an appropriate and timely way that people liked, by friendly staff. If there were any problems staff resolved them quickly. One person said, "Anything you ask for, you get." Another person told us, "They do things when I need them." A relative said, "Just a fantastic team." During the inspection people approached staff and the registered manager for assistance or with questions and were responded to in a positive, calm and unrushed manner.

Staff described the assessment process before people moved in. People and their relatives were provided with written information about the home and organisation. It outlined what they could expect from the home and what the home's expectations of them and their conduct was. The home requested assessment information from service commissioners and hospital or a previous care home if people were being transferred. The home also carried out its own assessments. These assessments identified if people's needs could be met and if so people were invited to move in if they wished. This was after people and their relatives had been invited to visit, to see if they liked the home. They could visit as many times as they wished before deciding if they wanted to move in.

People's care plans were comprehensive, up to date and contained sections for all aspects of their health and wellbeing. They included consent to care and treatment, medical history, mobility, dementia, personal care, recreation and activities, tissue viability guidance and preventing pressure damage. The care plans were underpinned by risks assessments and reviewed by people and staff. Daily notes identified if required support and chosen activities had taken place. There were individual communication plans and guidance in place. Focussing on people as individuals was also promoted by the development of their 'Social and life histories' that outlined events of particular significance to them. These were live documents and added to by people and staff when information became available through daily conversations.

There were a number of activities available on a daily and weekly basis as well as visiting entertainers, religious services and there were three activities co-ordinators. Activities included movie mornings, musical bingo, arts and crafts, gentle exercise, coffee mornings, balloon tennis and quoits. There were also 'Pat the dog' sessions on the weekend. A quiz was taking place during our visit. The home also had links with a local nursery and junior school with children visiting people. There were also visits from Duke of Edinburgh Award students from a local senior school. One person said, "Always plenty to do, I play quoits." A relative said, "The entertainment girls are fantastic and engage with the residents really well."

People 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 with complaints acted upon and learnt from. People's care and support was adjusted accordingly to reflect this. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people to make complaints or raise concerns. Any concerns or discomfort displayed by people was attended to sensitively during our visit.

Good

Is the service well-led?

Our findings

People and their relatives said the registered manager and staff were approachable and made them feel welcome and comfortable. One person said, "The [Registered] manager speaks to all the residents." Another person told us, "The [Registered] manager is excellent." A relative said, "The [Registered] manager is really good."

The home had an open, listening culture with staff and the registered manager paying attention to and acting upon people's views and needs. People's conversation and their positive body language showed that they were equally comfortable talking to the registered manager as they were with the staff. People and their relatives thought the home was well managed. People confirmed that home open meetings regularly took place where they could express their views. There were minutes of the meetings on the floor noticeboards. Annual questionnaires were also sent to people and their relatives.

The organisation's vision and values were clearly set out. Staff understood them and said they were explained during induction training and regularly revisited. The management and staff practices reflected the vision and values as they went about their duties. People were treated equally, with compassion, listened to and staff did not talk to them in a demeaning way.

Staff told us the registered manager was supportive. Their suggestions to improve the service were listened to and given serious consideration. There was a whistle-blowing procedure that staff had access to and said they would feel comfortable using. They said they really enjoyed working at the home. A staff member said, "A very nice place to work, a lot of staff have been here a long time and the [Registered] manager is hands on and very helpful." Another staff member told us, "A good boss, I've been working here twelve years." The records we saw demonstrated that regular bi-monthly staff supervision and staff meetings and annual appraisals took place.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support as required. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way. The home had also developed strong partnership links with the Princess Alice Hospice and 'Embracing Age' voluntary service. There was also an organisational newsletter titled 'Fulfilling Lives'.

There was a robust quality assurance system that identified how the home was performing, any areas that required improvement and also those where the home was performing well. This enabled any required improvements to be made. Quality audits included medicine, health and safety, infection prevention and control, activities and MCA and DoLS. There were also daily checklists of the building, cleaning rotas, and people's care plans. Policies and procedures were audited regularly. Shift handovers that included relevant information about people.