North Yorkshire County Council

White Rose House

Inspection report

Northallerton Business Park
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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 27 July and 2 August 2016. We gave the provider 48 hours' notice of our visit to ensure someone would be available.

White Rose House provides personal care at home through short term assessment and re-ablement teams (START). These offer short term support to help people with a disability remain independent, and also help people regain their independence after an accident or period of ill health. After a six week period of support, people's needs are reassessed, and they are either discharged from the service, or offered continuing support from social care services. Support is also provided within an extra care housing scheme, where some of the people who use the service live as tenants. On the day of our inspection there were 27 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection visit, the registered manager was on secondment and the service was being managed by the provider's care services manager and home care manager.

White Rose House was last inspected by CQC on 15 May 2014 and was compliant with the regulations in force at that time.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. People who used the service said they usually saw the same member of staff and staff always arrived on time.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

Staff had been trained in safeguarding vulnerable adults. Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

Accidents and incidents were appropriately recorded and analysed and risk assessments were in place for people who used the service.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA) and people's consent for their care and support had been obtained.

Staff were aware of people's specific diet and nutrition needs. People who used the service had access to healthcare services and received ongoing healthcare support.

People who used the service were complimentary about the standard of care provided by White Rose House. Staff treated people with dignity and respect and helped promote people's independence.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person centred way.

The provider had an effective compliments and complaints policy and procedure in place and people were aware of how to make a complaint.

People were supported to explore new opportunities in the community, to help meet their social needs.

Staff felt supported by the management team and were comfortable raising any concerns. People who used the service and staff were regularly consulted about the quality of the service and had positive things to say about the management and how the service was run.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Staff had been trained in how to safeguard vulnerable adults.

Accidents and incidents were appropriately recorded and analysed, and risk assessments were in place.

Appropriate arrangements were in place for the administration and storage of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff at mealtimes and staff were aware of people's nutritional needs and individual preferences.

Care records contained evidence of visits to and from external health care specialists.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff were able to describe the individual needs of people who used the service and how they wanted and needed to be supported.

Staff treated people with dignity and respect and independence was promoted.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

Care records were regularly reviewed and evaluated and up to date.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had a positive culture that was person-centred, open and inclusive. People who used the service said they could approach the management at any time.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff said the management were approachable and they felt supported in their role.

White Rose 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 27 July and 2 August 2016. We gave the provider 48 hours' notice of our visit to ensure someone would be available.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work. We have incorporated the feedback we have received into the report.

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 used this information to inform our inspection.

During our inspection we spoke with five people who used the service. We also spoke with the care services manager, home care manager and four members of staff.

We looked at the personal care or treatment records of six people who used the service and observed how people were being cared for. We also looked at the personnel and training records of four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Our findings

People who used the service told us they felt safe with the staff at White Rose House. They told us, "Very safe", "You feel safe in these flats", "I know they are there if I need them. I just press my lifeline. It reassures me" and, "There's always someone on at night so I press a button and they come straight away".

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We looked at staffing rotas and discussed staffing levels with the home care manager who told us any absences were covered by their own permanent staff and agency staff were used as a last resort. The home care manager told us that the management team would also cover absences if required. The service operated a management out of hours duty rota so a member of the management team was always available if required. Staff we spoke with did not raise any concerns about staffing levels and confirmed they covered absences among the permanent staff team. People who used the service told us they usually saw the same member of staff, and although they didn't always know who was visiting, it was always someone they were familiar with and the member of staff always arrived on time. This meant people who used the service were looked after by familiar and consistent staff.

Risk assessments were in place for people who used the service and described potential risks, factors that increased the risk, triggers and warning signs, risk reduction methods and the outcome. Risk assessments included risk of falls, risk of hallucinations/confusion and risk of malnutrition and dehydration. For example, one person was identified as being at risk of choking. Risk reduction methods included ensuring the person was sat in an upright position and the person's diet followed guidance provided by the relevant health care professional.

People had home care checklist risk assessments, which included accessing and leaving the premises, risks

inside the premises, general risks, moving and handling and other hazards. All of the records we saw were up to date.

We saw a copy of the provider's health and safety policy. Staff were provided with guidance on lone working and a risk assessment was in place for lone working and driving in hazardous conditions. The provider also had an emergency and a contingency plan in place in the event of bad weather and any other unforeseen events. This meant the provider had taken seriously any risks to people and staff and put in place actions to prevent accidents from occurring.

We saw a copy of the provider's safeguarding policy and records of safeguarding incidents, which had been appropriately referred and investigated. CQC had been notified via statutory notifications for these incidents.

The home care manager told us safeguarding was on the agenda at every team meeting and in staff supervision sessions. Staff were given scenarios to talk through and not just asked if they were aware of safeguarding. If the supervisor identified an issue with the staff member's understanding of safeguarding, further training would be arranged. Safeguarding training included the completion of a safeguarding adults workbook. We found the provider understood the safeguarding procedures and had followed them.

Accidents and incidents were recorded and paper copies were retained in each person's records. These provided information about the person who had the accident, details of the accident and details of any injury. All accidents and incidents were recorded on the provider's electronic system and analysis was carried out by the provider's accident team to identify any patterns or trends.

We looked at how medicines were managed. People who used the service were assessed using a 'Medication assistance screening tool'. This assessment asked questions, such as whether the person was able to obtain their own supplies of medicines, whether they could read the labels or get the medicines out of the container, whether they would remember to take their medicines or had any other difficulties taking medicines. We saw one person wasn't able to administer their own medicines because of, "Poor eyesight, unable to read print. Staff to administer medicines" and "Due to stroke, unable to get out of package". This person had signed a consent form agreeing to staff helping them with medicines.

People who had their medicines administered by staff had medicine administration records (MAR) in place. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. MARs we saw included details of the person's address, date of birth, whether they had any allergies and GP details. All the MARs we saw were up to date and initialled by staff.

Medicines were stored in locked cupboards in people's own accommodation. Staff received medicines competency assessments, which were designed to be used following safe handling of medicines training to ensure the training had been embedded into practice. These were carried out at least every 12 months and involved the member of staff being supervised preparing to administer, and administering, medicines to people who used the service.

Medicines audits were carried out every month. These checked whether MARs were accurately completed, and whether medicines were available and correctly administered. Any issues were identified and recorded, discussions took place in supervisions, action plans were put in place and staff were made responsible for improving their practice. This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Our findings

People who used the service received effective care and support from well trained and well supported staff. People told us, "The staff are absolutely fantastic", "Communication is good. There's always someone there" and "They [staff] are fantastic".

We looked at staff training records and the provider's electronic training dashboard. Staff mandatory training included compliments, comments and complaints, customer care, equality and diversity, health and safety, information management, data protection, freedom of information and information security. Staff also received role specific training. These included first aid, mental capacity, safeguarding, moving and handling, food safety and nutrition and making every contact count. Making every contact count aims to improve people's lifestyles and reduce health inequalities, for example, smoking, healthy diet and weight, exercise and alcohol intake.

Staff training was carried out by a combination of online learning, classroom based learning and cascade training by management. The training records we saw were up to date and the care services manager told us the provider's electronic system was used to monitor training and highlighted if any training was due. All staff had access to their own 'Learning zone' which they could log on to monitor their own training. Staff told us they had received all the training they need to be able to do their job. This meant people who used the service received care and support from well trained staff.

All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care. New staff also completed an induction to the service, which included workplace familiarisation, awareness of the provider's policies and procedures and completion of mandatory training. Induction and probationary reviews took place after one month, three months and five months, and staff were signed off as permanent staff after being assessed as competent in the role.

Staff received regular supervisions and an annual appraisal. Supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff also received observations in the workplace, which checked whether they were wearing the correct uniform, ID badge and personal protective equipment (PPE), whether the staff member was polite and respected the person's dignity and promoted independence, and whether documentation was correctly completed. Staff told us they received regular supervisions and appraisals. One staff member told us, "I have received a lot of support from day one." This meant staff were fully supported in their role.

Staff were aware of people's specific diet and nutrition needs. For example, one person who used the service had dysphagia. Dysphagia is difficulty or discomfort in swallowing. The person's care records included records of visits from the speech and language therapist (SALT) and recorded the guidance SALT had provided. This person also had a risk assessment in place due to the risk of choking. We saw from a recent visit that this person's symptoms had reduced and they could now have normal fluids and a normal diet but to continue to avoid tough textures.

We saw another person could meet their own dietary needs. The person independently made hot and cold drinks and could prepare food using the cooker and microwave.

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. We checked whether the service was working within the principles of the MCA. Management and staff we spoke with had a good understanding of the principles and their responsibilities in accordance with the MCA and were provided with information on mental capacity via newsletters, briefings and training sessions. All of the people who used the service at the time of our inspection visit had the capacity to make their own decisions.

Consent had been obtained from people for the care and support they were provided with. Consent forms were in place for help with medicines, the destruction of unwanted or discontinued medicines and consent for community care and carer assessments.

None of the care records we looked at included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. DNACPR means if a person's heart or breathing stopped as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). The care services manager told us although there were no DNACPRs in place, staff were aware of them.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs and district nursing teams.

Good

Our findings

People who used the service were complimentary about the standard of care they received from staff from White Rose House. They told us, "They are all very caring" and "They are really like friends now".

Staff we spoke with were able to describe the individual needs of people who used the service and how they wanted and needed to be supported. People we saw looked comfortable with staff and we observed staff talking to people in a polite and respectful manner, and interacting with people at every opportunity.

The service used a pictorial resource to help provide information to people and assist with communication. This included recipes and meal ideas, personal care and morning and night routines, medication, how to use appliances such as oven, washing machine and tumble drier, cleaning, shopping, personal safety and making choices. We saw in one person's care record that the person had been provided with information on the START service in picture format which had helped the person to understand the process and service provided.

Staff we spoke with told us they respected people's privacy and dignity. They told us, "From day one, staff are told people must be treated as individuals" and "We always knock on the door first. We respect the person's wishes". We observed in the extra care housing scheme that to respect people's privacy, staff knocked on the door or rang the doorbell before entering people's accommodation.

We asked people who used the service whether staff respected their privacy and dignity. They told us, "They are very up on dignity here" and "They always ring the bell before they come in".

Support intervention plans described how START worked with people to regain their independence. They described what actions staff were to take to help people achieve their goals and outcomes such as regaining their confidence and becoming fully independent. For example, one person required assistance with getting out of bed and washing the bottom half of their body due to being unsteady on their feet. The person also required support and encouragement to access the kitchen and prepare meals. The goal for both of these was for the person to become fully independent. We saw that from the weekly progress reports that this person was starting to make improvements and regain some independence. For example, "[Name] has managed a full strip wash this week, managing to get up and out of bed and get themselves to bed." We saw another person had told staff that they were struggling opening tins. Staff advised the person to purchase an electric tin opener and the person thought this was a good idea.

Daily contact sheets documented the care carried out and support given at each visit, and showed how people were able to make choices, had their privacy and dignity respected and their independence promoted. For example, on one morning visit staff recorded that the person was already up and had carried out their own personal care. Another person's daily contact sheet stated, "[Name] made own sandwich and also buttered a teacake for their tea."

The care services manager told us some members of staff were dignity champions and dignity awareness was raised via posters in the office and discussions at team meetings. Dignity champions are staff members who promote dignity in the service through staff meetings and training sessions. People who used the service were given 'dignity cards' when they began using the service. This advised people of their rights and what they should expect from staff with regard to dignity.

This meant that staff treated people with dignity and respect and promoted independence by encouraging people to care for themselves where possible.

We discussed advocacy for people who used the service with the home care manager. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The home care manager told us some of the people who used the service had advocates and provided us with an example where advocacy had been recommended to a person who used the service. The advocate was involved in decision making, for example, with regard to the care service the person received and helped the person in making financial decisions.

Good

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated. People's needs were assessed before they started using the service. This ensured staff knew about people's needs prior to carrying out care and support.

People who received care from the short term assessment and re-ablement teams (START) had support intervention plans in place. The support intervention plans included communication, personal care, eating and drinking, practical aspects of daily living, social contacts and leisure, learning and work, choice and control, keeping safe, managing my actions, being a parent and unpaid support. Each category was given a score depending on how much assistance the person required with the aspect of their life. The scores ranged from fully independent to requiring total assistance in that area.

Support intervention plans were person centred and described what was important to the person, what the person's identified goals and outcomes were, and how they would be achieved. The support plans contained evidence that people had been involved in writing the plan and their wishes were taken into consideration. For example, one person wanted to overcome their diagnosis and re-motivate themselves to live independently. Another person had been admitted to hospital due to decreased mobility. Following the person's hospital admission, their mobility was improving but they lacked confidence in that area and required some additional support.

The support intervention plans clearly described action staff were to take to help the person achieve their goals. For example, "[Name] will need encouragement and some initial support and assistance to get out of bed and to access the bathroom" and "Support and encouragement to access the kitchen to prepare lunch".

People were assessed weekly during the six week programme to see how they were progressing and to see what further interventions were required after six weeks, or whether the person was able to live independently. The home care manager explained to us that sometimes people continued to use the START service after six weeks if it was agreed it was in the person's best interests to do so.

People who lived in the extra care housing scheme and received long term care and support, had service plans in place which had an assessed outcome. For example, administration of medicines, assistance to wash and dress and food and drink preparation. The plan described how the outcome would be met and tasks staff were to carry out at each visit. For example, "45 minute call to administer medication, assist with

personal care, washing, dressing and changing stoma bag, food and drink." The plan also described what additional equipment was required, for example, stand aid, shower chair, grab rails in the bathroom and zimmer frame.

Daily contact sheets recorded each visit to a person who used the service and included the date and time of the visit and a summary of the care provided. For example, what personal care was carried out, meal choices and routines, medicines, evidence of contact with health professionals or any other significant occurrence.

People who used the service were supported to attend events and activities in the community. The service provided a monthly list of events and activities, including locations, dates and times, and provided the list to people who used the service. Events and activities included, films, theatre productions, exhibitions, museum events, dance classes, arts and crafts, race meetings and concerts.

We saw one person who used the START service had been supported to explore new opportunities in the local community. Staff accompanied the person to attend groups until they felt confident to attend on their own. The person volunteered at a local organisation and START arranged for additional volunteering time there. We saw from the person's care records that they attended a local knitting group, coffee mornings, a craft group, Christmas parties, and went on coach trips.

We saw a copy of the provider's complaints and compliments policy and procedure. Each person who used the service was provided with a complaints leaflet and the provider's service information guide provided details on how to make a complaint, including the contact details of who to report a complaint to.

We looked at the commendations and complaints book and found there had not been any formal complaints made in the previous 12 months. People we spoke with did not have any complaints about the service. There had been several compliments made about the service. Comments included, "I have enjoyed the START team coming here to help me. They are so wonderful to me", "We very much appreciate everything that was done to help [Name]" and "Thank you for what you have done for me. You have helped me in a big way". This showed the provider had an effective compliments and complaints policy and procedure in place.

Good

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. At the time of our inspection visit, the registered manager was on secondment and the service was being managed by the provider's care services manager and home care manager.

We saw a copy of the provider's statement of purpose, which described the aims and objectives of the provider, the kinds of service provided, details of the provider and registered managers and locations where services were provided from.

The service had a positive culture that was person-centred, open and inclusive. Staff we spoke with felt supported by the management team and told us there was an open door policy and they were comfortable raising any concerns. They told us, "[Management team] are very approachable. If I have any concerns, they are there to help", "Very open, from day one" and "The [home care manager] is very supportive. We've learned a lot from them". The provider held an awards event every year to celebrate the success of their staff and staff could nominate colleagues for awards.

People who used the service told us, "It always gets sorted if anything goes wrong", "[Staff member] is very good. If you tell them anything that's wrong, they'll sort it for you" and "If I need anything I can contact the office".

The care services manager told us the provider supported management teams in a variety of ways. These included senior management attending chief executive staff events, where key messages were shared and question and answer sessions took place with the chief executive. All senior managers attended leadership forums, which provided updates on the provider's organisation and strategy.

Meetings and forums were held to share best practice and ensure consistency across the provider's services. These included a care services manager forum, which focused on county wide issues, trends and changes in policies and procedures. A manager's meeting was also held monthly. Local team meetings were held every four to six weeks, where information from these meetings and forums could be disseminated to staff.

We looked at the most recent staff meeting minutes from 22 July 2016. The agenda included complaints and commendations, health and safety, risk assessments, lone working, cleaning, safeguarding, support plans, medicine audits, procedures and legislation, moving and handling, and recruitment.

In house team meetings also took place where staff would discuss each of the people they supported and update on any changes, for example, following hospital admissions or changes in health.

The provider carried out a staff survey "Social care health check" in July 2016. The included areas such as workforce stability, retention and experience, staff roles and resources, communication and staff support, staff engagement and rewards. Individual locality action plans were developed from the responses.

This meant staff were regularly consulted and kept up to date with information from the provider.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. Each person who used the service received an annual quality assurance check. This involved a senior care staff member visiting the person in their own home and carrying out a check to see whether the person was happy with the service and whether they had any additional needs. Actions were noted where required, as well as additional comments from the person who used the service. An annual corporate survey was also sent out to people who used the service.

We saw a copy of the monthly management report, which was completed by the home care manager and forwarded to the care services manager for review. This included a report on staffing, management information, safeguarding and complaints and commendations. For example, the medication section provided updates on any medication incidents and medication audits.

The management team maintained a spreadsheet that included the dates and due dates for environmental risk assessments, service provision plans, quality visits, falls risk assessments, medication screening tools and meal time support plans for each person who used the service.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources.