Richmond Psychosocial Foundation International

The White House

Inspection report

91 Heathfield North
Twickenham
TW2 7QN

Tel: 02087441330
Website: www.rpfi.org

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection that took place on 30 June and 3 July 2017.

The home provides care and support for five people with learning disabilities and is located in the Twickenham area.

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.

In May 2015, our inspection found that the service required improvement in the area safe regarding a small proportion of the medicine records which were incomplete for creams administered. All the other key questions were rated good with an overall good rating. At this inspection the service was rated overall good with good in all the key questions.

A relative and an advocate told us that they thought the service the home provided was good and people using the service told us and their body language indicated that they enjoyed living at the White House and felt it was their home. During our visit people chose the activities they wished to do such as drawing. People took part in activities as a group or individually depending on the nature of the activity and their preferences. The staff team provided the care and support people needed in an individual, person centred way including during group activities with people receiving the care and attention they needed to enhance their enjoyment.

The home's atmosphere and environment was inclusive, warm and enabling towards people using the service and their visitors with a lot of laughter and smiling taking place during our visit. It was well maintained, furnished, reasonably clean and a safe environment for people to live and work in.

The records were well maintained, up to date, regularly reviewed and enabled staff to support people using the service appropriately.

The staff knew people using the service, their likes, dislikes and routines well including how they wished to be supported. They had appropriate skills and received training that was focussed on providing individualised care and support in a professional, friendly and supportive way. They also made themselves accessible to people using the service when required. Staff said they had access to good training and support.

People were provided with balanced diets that protected them from nutrition and hydration associated risks that also reflected their likes, dislikes and preferences. They were enabled to choose and help prepare meals if they wished to. People were also encouraged to discuss health needs with staff and had access to

community based health professionals, when needed.

The home's registered manager was approachable, responsive, encouraged feedback from people and 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?

Good

The service was safe.

A person's relative and an advocate said that people were safe and this was reflected in people's comfortable body language. There were effective safeguarding and risk assessment procedures that were followed. The home had appropriate numbers of well-trained and appropriately recruited staff.

People's medicine was administered safely and medicine records were up to date. Medicine was audited, safely stored and disposed of.

Is the service effective?

Good

The service was effective.

People received specialist input from community based health services. Their care plans monitored food and fluid intake and balanced diets were provided. The home was decorated and laid out to meet people's needs and preferences.

Staff received appropriate training.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff and people underwent mental capacity assessments and 'Best interest' meetings were arranged as required.

Is the service caring?

Good

The service was caring.

People felt valued, respected and were involved in planning and decision making about their care. The care was centred on people's individual needs.

Staff knew people's background, interests and personal preferences well and understood their cultural needs. They provided support in a kind, professional, caring and attentive way that went beyond their job descriptions. They were patient

and gave continuous encouragement when supporting people.

Is the service responsive?

Good

The service was responsive.

People had their support needs assessed and agreed with them, their families and advocates. They chose and joined in with a range of recreational activities. Care plans identified the support they needed and it was provided. A relative and an advocate told us any concerns raised with the home or organisation were discussed and addressed as a matter of urgency.

Is the service well-led?

Good

The service was well-led.

The home had a positive culture that was focussed on people. People were familiar with who the registered manager and staff were. The registered manager and staff enabled people to make decisions by encouraging an inclusive atmosphere.

Staff were well supported by the registered manager, management team and the training provided was good.

The home's quality assurance, feedback and recording systems covered all aspects of the service monitoring standards and driving improvement.

The White 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection and took place on 30 June and 3 July 2017.

This inspection was carried out by one inspector.

There were five people living at the home. We spoke with four people, two care workers, an advocate, a relative and the registered manager and new Chief Executive Officer.

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 checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

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

We looked at the personal care and support plans for two people using the service and two 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.

We contacted a health care professional to get their views.

Good

Is the service safe?

Our findings

People did not tell us about feeling safe at the home but their relaxed body language and positive rapport with staff indicated this. One person did say "I like it here." A relative told us, "The service is safe."

Staff were aware of what constituted abuse and had received training in how to identify abuse and the action to take if they encountered it. We asked staff what abuse was and the action they would take if they thought abuse was happening. They also had access to the provider's policies and procedures.

Staff were trained in safeguarding and understood how to raise a safeguarding alert and when they should do so. There was no current safeguarding activity involving the home and previous safeguarding issues had been suitably reported, investigated, recorded and learnt from by the home.

People's care plans contained risk assessments that enabled them to take acceptable risks and conduct their lives in a safe way. These included risk assessments about their health and aspects of people's daily living including social activities. The risks were reviewed regularly and updated if people's needs and interests changed. The risks were considered in relation to the benefits people would receive from activities and impact it would have on them, both if they did or did not participate.

The team shared information regarding risks to individuals during shift handovers, staff meetings and during shifts. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they would be comfortable using.

There were general risk assessments for the home and equipment used that were reviewed and updated. Equipment was regularly serviced and maintained.

When confronted with challenging behaviour, the home had a policy of de-escalation rather than restraint and staff had been trained in how to positively calm people who displayed behaviours that others may find challenging. They also knew what constituted lawful and unlawful restraint. There was individual de-escalation guidance contained in people's care plans if they required them and any behavioural issues were also discussed during shift handovers and staff meetings. They also monitored the affect the behaviour had on other people using the service.

The staff recruitment procedure recorded all stages of the process. The home used a recruitment agency that then provided a short-list of candidates for interview after considering prospective staff's curriculum vitae (CV) and a short telephone interview. The candidates were then invited to attend an interview. The interview contained scenario based questions to identify people's skills and knowledge of learning disabilities. References were taken up and security checks carried out prior to starting in post. There was also a six month probationary period that contained an initial review after three months.

The staff rota showed that the staffing levels met people's support needs and was also flexible to meet the needs of staff. This was reflected in the way people did the activities they wished when they wished. There

were suitable arrangements for cover in the absence of staff due to annual leave or sickness. The home had access to bank staff and to promote continuity of care, they requested staff who had worked at the home before and who people using the service were familiar with.

The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them.

People's medicines were administered safely. We checked the medicine administration records for people using the service and found that the records were completed correctly. The medicines kept at the home were appropriately stored in a locked facility and disposed of if no longer required. The staff who administered medicines were trained and this training was refreshed annually. They also had access to updated guidance.

Good

Is the service effective?

Our findings

During our visit people were supported and encouraged by staff to make their own decisions about the activities they wished to follow and support they needed. People's body language was positive towards staff and they said the care and support they received was what they needed. This was delivered in a friendly, enabling and appropriate way that people liked. Staff treated people equally, and gave them the time and attention they needed to have their needs met. One person told us, "I get on well with everyone living here." Another person said "I'm enjoying myself." An advocate told us, "Staff are really involved in people's health needs, any problems and health care needs are followed up."

Staff were in receipt of mandatory induction and refresher training and the home's training matrix identified when mandatory training was due. This training included infection control, restraint and de-escalation, fire awareness, food hygiene, equality and diversity and first aid. The registered manager explained that the induction encompassed the 'Care Certificate Common Standards' and the expectation was that the certificate modules would be completed within two months. There were monthly staff meetings that gave an opportunity to identify further training needs. Two monthly supervision sessions and annual appraisals were partly used to identify any gaps in training. Staff had training and development plans in place. Experiences were also shared with other homes within the organisation. When new staff were recruited they would shadow more experienced staff during shifts to enhance their knowledge of people using the service and the home's operational procedures. The induction process also included familiarisation with the organisation and the home that included people using the service, their care plans and behavioural assessments, home layout and the provider policies, procedures and shadowing staff on shift.

We observed staff communicating with people clearly and at a pace that enabled them to understand what was being said and its meaning. People were also given the opportunity to respond. The care plans and other documentation such as the complaints procedure were part pictorial to make them easier to understand.

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 whether 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 MCA 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 MCA and DoLS. Staff we spoke with understood their responsibilities regarding the MCA and DoLS. During our visit staff continually checked that people were happy with what they were doing and activities they had chosen.

People's care plans had sections for health, nutrition and diet. Full nutritional assessments were done and regularly updated. If required, weight charts were kept for people and staff monitored how much people had to eat. Staff had access to information about the type of support people required at meal times. Staff said any health related concerns were raised and discussed with the person's GP. Nutritional advice and guidance was provided by staff and there were regular visits by health care professionals based in the community as required. People had annual health checks. The records demonstrated that referrals were made to relevant health services when required and they were regularly liaised with. One person said the food was what they liked.

Good

Is the service caring?

Our findings

Staff listened to people, valued their opinions and were aware of their needs and met them. They were friendly, helpful and kind towards people. One staff member said, "I feel they (People using the service) are part of my extended family." The home provided a comfortable, relaxed atmosphere that people's body language demonstrated and people said they enjoyed. People told us that staff treated them well and we saw people were treated with dignity and respect. They enjoyed a good quality of life and were supported to do as they wished. One person told us, "Staff are good, but I have my favourites." An advocate said, "There are some lovely staff here." A relative said, "Staff are very good."

The care practices we saw demonstrated that staff were skilled, and knew people's individual needs and preferences very well. Staffs' patient approach to providing people with care and support meant that people were consulted about what they wanted to do, where they wanted to go and who with. They also made the effort to ensure people enjoyed themselves and their wishes were put first. Staff encouraged people to join in with activities including household tasks such as laying the table and putting rubbish out by making them fun tasks and staff made sure no one was left out. When people returned home, they were asked how their day was and what they had been doing. This included other people using the service as well as staff and made the home's atmosphere a family environment. The home provided an inclusive environment by encouraging people to eat together making mealtimes an enjoyable event and promoting interaction.

Personal information including race, religion, disability, likes, dislikes and beliefs was included in people's care plans and this information enabled staff to respect people, their wishes and meet their needs. The range of activity options offered to people, by staff, during our visit demonstrated this as they were based on people's recorded likes and dislikes. Staff received training about respecting people's rights, dignity and treating them with respect.

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

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. People said they had visitors whenever they wished, and they were always made welcome and treated with courtesy. The home held a welcome party for someone who had recently moved in and there was another one planned for them that their relatives would be attending.

Good

Is the service responsive?

Our findings

People, a relative and an advocate confirmed that staff and the registered manager asked for their views and opinions and this happened throughout our visit with people being asked what they would like to do and if they would like to join in with the activities taking place, such as drawing. They were also given time to decide what they wanted to do and the support they needed to do it. Any problems that arose were quickly resolved by staff and people using the service. One person said, "I've been out shopping and got a can of coke." Another person said, "I'm going to a street party." An advocate said, "[person using the service] has a full week and it is the right balance between structured activities and spontaneous choice, although there could be more on the weekends."

The local authority referred people and provided assessment information. Information from their previous placement was also requested if available. This information was initially shared by the organisation's management team to identify if people's needs could be met. People were then invited to visit the home for an on-site needs assessment by the registered manager. The registered manager said this was important as it gave a more focussed view of what people's needs may be in the home's environment and how long it may take them to settle in, as opposed to their previous home where they would be more in their comfort zone with familiar faces and environment. People, their families and other representatives were fully consulted and involved in the decision-making process prior to moving in. They were invited to visit as many times as they wished before deciding if they wanted to use the service. The registered manager and staff would add to the assessment information during the course of these visits.

Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual. It was also important to get the views of those already living at the home.

Written information about the home and organisation was provided and there were regular reviews with people and their relatives. This included a review after six weeks. During this period a key worker would also be allocated. If there was a problem with the placement, alternatives would be discussed, considered and information provided about prospective services where needs might be better met.

People's needs were regularly reviewed, re-assessed and care plans updated to reflect their changing needs and to check that the placement was still working. The care plans were individualised, person focused and developed by people and their keyworkers. The care plans became more refined as more information was available and people's likes, dislikes, needs and wishes, were further identified. They were comprehensive and contained sections for all aspects of health and wellbeing. They included care and medical history, mobility, personal care, recreation and activities, and behavioural management strategy. They were part pictorial to make them easier for people to use. They contained individual communication plans and guidance.

The care plans detailed goals that were identified and agreed with people where possible. The goals were underpinned by risks assessments and reviewed monthly by keyworkers who involved people who use the service. If goals were met they were replaced with new ones. The care plans recorded people's interests and

the support required for them to participate in them. Daily notes identified if the activities had taken place.

The activities people pursued were a mixture of individual and group with a balance between home and community based activities. Each person had their own weekly individual activity plan. One person worked at a horticultural centre and another at a department store in Richmond. One person attended a weekly dance course at college. As well as regular activities there were also seasonal ones such as an Easter egg hunt, birthday parties and barbecues that relatives and friends were also invited to. During our visit one person was attending an aromatherapy session. The activities that took place included music, massage, sensory sessions, canvas and cocktails, bowling and craft sessions. People were joining in a drawing session during our visit. One person said, "I'm seeing my mum on Friday, she lives in Putney and I'm going by car." This was a regular occurrence. People also improved their life skills by taking responsibility for tasks such as gardening and keeping their rooms tidy. One person said, "I keep busy during the day."

People told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them and was part pictorial. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly.

There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

Any concerns or discomfort displayed by people using the service were attended to during our visit.

Good

Is the service well-led?

Our findings

People told us they liked the registered manager and a relative said they were approachable and made them feel comfortable. An advocate said, "There is good interaction with the manager and they have a willingness to find solutions." When we visited the home had an open, listening culture with staff and the registered manager taking people's views on board and acting upon then.

The organisation had a clear vision and values that staff we spoke with were aware of and understood. These had been explained during induction training and regularly revisited. The registered manager and staff practices reflected the vision and values as they went about their duties. People were treated equally, with compassion; staff listened to them and were not condescending.

The organisation had a new Chief Executive Officer (CEO), who spent a lot of time with people using the service and there were now much clear lines of communication within the organisation and specific areas of responsibility and culpability.

Staff said they found that the registered manager was very supportive towards them and their service improvement suggestions were listened to by the registered manager and CEO and given serious consideration. Staff told us they liked working at the home. One staff member said, "I love it here, I didn't know if I could transition to proving care for people with learning disabilities, but am so glad I did." Another member of staff told us, "I feel very supported and the communication and teamwork is so much better."

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in need and support as required.

The home's records showed that safeguarding alerts and accidents and incidents were fully investigated, documented and procedures followed correctly. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

The new CEO was looking to introduce further quality assurance processes such as manager peer monitoring visits within the organisation. The home had a quality assurance system that regularly checked care plans, risk assessments and daily notes were up to date. Health and safety checks were completed that included the building, fridge and freezer temperatures, fire alarms and call points, hot water temperatures and any electrical goods. Equipment used was regularly serviced and maintained under contract.

The home checked service quality at weekly house meetings and had telephone and e-mail contact with relatives as well as speaking to them when they visited. Shift handovers also took place that included information about each person.