Caring Consultancy Limited

Whitefriars Nursing and Residential Home

Inspection report

9 Dormers Wells Lane
Southall
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Tel: 02085740156

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17 February 2017

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Ratings

Overall rating for this service	Good
Is the service safe?	**Good**

Summary of findings

Overall summary

This inspection took place on 17 February 2017 at 10:30 pm and was unannounced. At the last inspection on 28 April 2016 we rated the service as Good for all of the five questions we ask about services and Good overall. There were no breaches of the Regulations at our last inspection.

Whitefriars Nursing and Residential Home provides accommodation and nursing care for up to 28 older men and women. The provider is also registered to provide personal care to people living in their own homes but this service was not operating when we carried out this inspection.

The provider's Nominated Individual is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out this unannounced, out of hours inspection after we received information of concern from the local authority's safeguarding adults team. The information alleged that staff locked people's bedroom doors at night to prevent them from wandering and to keep them safe. We found no evidence at this inspection to substantiate the allegations.

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 supported to make choices about their care at night and staff respected these.

There were enough staff on duty at night to meet people's care needs.

The provider made unannounced night-time visits to monitor standards of care at night.

Whitefriars Nursing and Residential 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 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.

The inspection was prompted by allegations made to the local authority's safeguarding adults team that staff locked people's bedroom doors at night. The information shared with CQC about the incident indicated potential concerns about the management of risk and that people may not have had the support they needed in the event of an accident. The information also indicated that staff may have deprived people of their liberty unlawfully. This inspection examined those risks.

This inspection took place on 17 February 2017 at 10:30 pm and was unannounced. One inspector carried out the inspection.

Before the inspection we reviewed the information we held about the provider and the service. This included the last inspection reports and statutory notifications the provider sent us of significant incidents and events affecting people using the service.

During the inspection we spoke with staff on duty and saw all parts of the service.

Following the inspection we discussed the concerns with the provider and informed the local authority's safeguarding team that there was no evidence to substantiate the allegations made to them.

Good

Is the service safe?

Our findings

On 17 February 2017 the local authority's safeguarding adults team passed information of concern to the Care Quality Commission (CQC). The information alleged that staff in the service locked people's bedroom doors at night to prevent them from leaving their rooms. We agreed that CQC would carry out an unannounced, out of hours inspection on the same night.

When we arrived at 10:30 pm the nurse in charge answered the door bell immediately and checked our identification before allowing entry to the service. We saw that there were sufficient staff to meet people's care and support needs through the night as the nurse in charge was on duty with two health care assistants.

One person using the service was awake and sitting in the ground floor lounge. All other people were in their bedrooms. The nurse in charge was finishing the evening medicines round and we walked around the service with her while she did this. Most people had their bedroom doors open and door holders linked to the fire alarm system were fitted to ensure the doors closed if the fire alarm sounded. We saw that some people were asleep in bed, while others were awake and watching TV or listening to the radio.

We did see that six bedroom doors were shut. We tried each of these and were able to open all of the doors except one. We asked the nurse in charge about this and she told us the person valued their privacy and always locked their door.

Throughout our visit we found no evidence to substantiate the allegations made to the local authority. We saw that people were offered choices about the time they went to bed, whether they wanted their bedroom doors open or closed and what time they settled to sleep for the night. There were enough staff to meet people's needs and nobody waited for care and support, if they needed it. The staff on duty worked well together to ensure they supported people and the nurse in charge had time to complete the evening medicines round without distractions.

Following the inspection we discussed the allegations with the provider. They told us this would not be acceptable practice and they would take action if they found this was happening. The provider appointed a clinical lead in 2016 and they had carried out two unannounced night-time inspections between March and December 2016. In the same period they provider told us they had also carried out one unannounced night-time visit. There had been no concerns identified at any of the three visits. The provider also told us that if their pre-admission care needs assessment of a person indicated they may wander at night, they would be offered a room on the ground floor of the service. This meant they could leave their room to walk around and use the communal lounges without the risk of falling on the stairs. They also told us that if a person's care needs changed and they began to wander at night, they would discuss this with the person's family and relevant professionals to agree a plan of action. They told us this may involve moving the person to a bedroom on the ground floor to mitigate the risks of their wandering. The provider also told us they would continue their night-time monitoring visits to ensure people were cared for safely in the service.