Mrs Anita Larkin

# White Hill House Residential Home for the Elderly

**Inspection report**

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## Ratings

| Overall rating for this service | Good |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

## Overall summary

White Hill House Residential Home for the Elderly is a family run care home which accommodates up to 8 people. It does not provide nursing care. At the time of our inspection there were seven people living at the home.

White Hill House Residential Home for the Elderly are not required to have a registered manager in place because they are a sole provider and the registered provider has overall responsibility for the day to day management of the home. Registered persons have been registered with the Care Quality Commission and have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

# Summary of findings

The inspection took place on 24 July 2015 and was carried out by one inspector. This was an unannounced inspection which meant staff and the provider did not know we would be visiting.

There was a warm, friendly atmosphere within the home and people received care and support in an unrushed calm manner. Staff treated people with dignity and respect and made time to sit with people and spend some quality time with them on a one to one basis.

It was evident staff had built up good positive relationships with people who lived in the home and with their families and friends.

Staff were very knowledgeable about the needs and histories of people who lived in the home and what they required support with and what they could do themselves.

The service worked in a way which kept people safe from harm. Any individual risks to people's health, care and welfare had been assessed with risk management plans in place to prevent them from any avoidable harm. Any health and safety concerns were documented in people's care and support plans. They were regularly reviewed and updated where any changes were evident.

Safe recruitment procedures were in place to ensure staff employed were of good character and fit to undertake their role. Staff were provided with an induction, on going training and supervision to ensure they met people's care and support needs safely and competently.

Staff we spoke with were happy working in the home. They were familiar with the whistle blowing policy and were confident to raise any allegations of poor practice to the management team.

There was a complaints procedure in place, although people we spoke with told us they had no reason to complain, that they were happy with the care and support they received. Likewise a relative we spoke with told us there had been no reason to raise any formal complaints. They told us that if they had any concerns they would speak with the provider, their deputy or staff and felt confident that any concerns raised would be dealt with appropriately.

Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how it related to people living in the home. The MCA sets out what must be done to ensure the human rights of people, who may lack capacity to make decisions, are protected. This includes decisions about depriving people of their liberty so they get the care and support that they need, where there is no less restrictive way to achieve this.

Staff we spoke with demonstrated an understanding of capacity and consent, and acting in people's best interests.

# Summary of findings

## 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 was safe.

Care and support was planned with people's health, safety and welfare in mind.

Staff understood their duty of care and responsibilities in relation to safeguarding people from harm. They were confident to use the whistle blowing procedure to highlight poor care practices.

There were sufficient numbers of appropriately trained staff to meet the individual needs of people who used the service.

Good

**Is the service effective?**
The service was effective

Where people lacked the mental capacity to make decisions the service followed the provisions of the Mental Capacity Act 2005 to ensure that any decisions were made in people's best interests and protected their human rights.

Systems were in place to ensure staff were trained, supported and monitored to meet people's individual needs effectively.

Good

**Is the service caring?**
The service was caring

People were treated with respect and their privacy and dignity were upheld and promoted.

Staff supported people in a caring, compassionate manner. They were familiar with people's needs and supported people according to their wishes and preferences.

Good

**Is the service responsive?**
The service was responsive

People were provided with activities and entertainment to ensure their social needs were met and to ensure they were not socially isolated.

People and/or their representatives were consulted with about their care and support needs and were fully involved in the development and reviews of their care and support plans.

Good

**Is the service well-led?**
The service was well led

There was an open culture within the home and the provider encouraged people to provide feedback on the care and services people received. This enabled them to make improvements to areas which mattered to people living in the home.

Staff felt valued and worked together well as a team. They found the management approachable and had no concerns in bringing any concerns to their attention.

Good

# White Hill House Residential Home for the Elderly

**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 24 July 2015 and was carried out by one inspector. This was an unannounced inspection which meant staff and the provider did not know we would be visiting.

Before the inspection we reviewed all the information we held about the service. We looked at previous inspection reports and notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

During the inspection we spoke with five people living at the home, the registered provider, four staff and one visiting relative. We looked at a number of records relating to individual's care and the running of the home. These included three care plans, one newly recruited staff's recruitment documentation, two further staff's personnel files and duty rota's. We also looked at staff training records, accident and incident records and records relating to the management of the service.

Good

# Is the service safe?

## Our findings

People who lived in the home told us they felt comfortable and safe and staff treated them well. They told us they would raise any concerns with staff if they had any. They told us they had call bells if they had any unexpected falls or accidents which were answered quickly. One person said "I feel very safe here. If I wasn't happy with something I would tell [named staff]. We don't have anything to complain about." We spoke with a relative who told us they had no concerns about the safety of their [relative] who lived in the home, they told us "I am extremely happy with the care she is getting, she is safe here".

Discussions with staff confirmed they had received safeguarding training during their induction, which was updated regularly thereafter. Staff understood their duty of care and their responsibilities in relation to safeguarding people from harm. Through discussions with staff, it was evident they were knowledgeable about what constituted abuse. They told us if they became aware of any suspicions or allegations of abuse they were to report them to their line manager However not all staff were able to cite the local authority as another means of contact if the need arose. We fed this back to the deputy who assured us they would arrange supervision for the said member of staff to ensure they were familiar with and confident in whom to report any concerns to if the need arose. We received confirmation the following day to inform us this had been undertaken and they had access to the contact details if they needed to make any referrals.

Staff we spoke with told us there was a whistleblowing policy in place and would use this if they had any concerns about their colleagues care practice or conduct.

We saw the care and support was planned and delivered in a way that ensured people's safety and welfare. Risk assessments had been completed with guidelines in place for staff to follow. These included moving and handling assessments, the likelihood of developing pressure damage, falls and nutritional assessments. These enabled staff to manage risk and promote people's comfort and safety. Staff we spoke with displayed a good knowledge of the needs of the people who lived in the home and how they managed any risks in relation to their care and support needs.

Accidents and incidents were recorded appropriately and were analysed to identify any trends so actions could be taken where possible to prevent any re occurrence. We read a sample of accident/incident reports which showed staff had taken appropriate action in response to them, such as calling for an ambulance, gaining advice from the GP and other healthcare professionals and informing the next of kin.

Safe procedures were in place for recruiting new staff. The recruitment files for staff showed recruitment checks had been carried out to ensure only suitable people were employed to work in the home. These included gaining references, full employment histories and checking criminal records to make sure they were of good character and safe to work with the people living at White Hill House Residential Home for the Elderly. Any gaps in a person's employment history was followed up and documented.

Staffing levels were determined according to people's assessed dependency levels. People told us they felt there were always enough staff available to meet their needs both during the day and night and had no concerns in this area. A relative we spoke with told us they were happy with the staffing levels and said "They have a high ratio of staff here." They told us the staff always kept them informed of any changes to their relatives health and responded to their needs appropriately.

The home was staffed by three carers from 8.00am to 4.00pm and two carers from 4.00pm to 8.00pm. There were no waking night staff but three staff and the registered provider lived on the premises and took it in turns to be on call should they be needed. Night time risk assessments were in place for each person who lived in the home. They covered the risks of getting up, wandering, continence, whether there were any moving and handling needs and ability to use the emergency call bell. We saw these were contained in each person's care plan and these confirmed there was no one in the home who required night time assistance. We were informed should people's dependency levels change to a level in which they required night time assistance the staffing rota would be changed accordingly in order to meet their individual needs. Staff told us they felt there were enough staff on duty to meet people's individual needs and they had time to spend quality one to one time with people who lived in the home. We observed there were sufficient staff to meet people's needs throughout our inspection.

Good

# Is the service safe?

People's life histories had been sought and documented within their care plans. These provided staff with a picture of the person's life history, their hobbies and interests, family connections and any memorable dates they liked to celebrate. We were informed people were invited to celebrate memorable occasions with staff and others living in the home. These included birthdays and anniversaries. This was confirmed to us by those we spoke with; one person added "They [staff] celebrate people's birthdays and it certainly doesn't go unnoticed."

Staff who handled medicines had completed appropriate training and their competency assessed to make sure they followed correct procedures in a safe manner. Medicine administration records were kept up to date and showed people received their medicines as had been prescribed by their GP. Systems were in place to regularly audit medicines within the home to ensure they were managed safely and in line with the homes policies and procedures. Where any concerns were highlighted, actions were taken. These were discussed with staff, the GP and where necessary the pharmacy to prevent a reoccurrence and maintain people's health and welfare. Processes were in place to enable people to continue to keep and administer their own medicines where they expressed a wish to do so. Where people maintained independence in relation to taking their medication this had been discussed and agreed within a risk management process. People who self-administered their medicines were provided with lockable facilities in which to store their medicines safely.

Arrangements were in place for responding to emergencies. For example, we saw that personal emergency evacuation plans were completed for people who lived in the home. These informed staff how people were to be evacuated in the case of an emergency such as fire. These were reviewed regularly to ensure they remained up to date and any changes had been documented. Similarly contingency plans were in place for unforeseeable events such as flooding. This meant the registered provider had plans in place to minimise the impact for such events and detailed how the service would resume normal operation following such events.

Good

# Is the service effective?

## Our findings

People were supported to have sufficient to eat and drink throughout the day and to maintain a healthy well balanced diet. We noted fresh fruit and nuts were readily available within the home for people to help themselves if they wished. The care plans we viewed contained nutritional screening assessments and records to show people were weighed regularly to ensure they received adequate nutrition and maintained a healthy weight. Information about people's specific dietary needs and the level of support they needed were also documented. Where there was a potential risk to people's nutritional and hydration needs, guidelines were documented on how staff were to manage the risk. Information about people's specific dietary needs and the level of support they needed was also documented. We noted one individual had food and fluid charts in place so staff could monitor their food and fluid intake. This was because they had recently lost some weight. We noted reference had been made to using brightly coloured crockery for one individual who tended to lose concentration during mealtimes and leave the dining table during the mealtimes. This showed staff looked at ways of meeting their individual needs so they found their mealtimes to be of interest and encouraged them to eat more.

People we spoke with told us were happy with the meals provided. They told us their breakfast was brought to them on a tray in their bedrooms and they generally took their lunch in the dining room with others. Comments included "The food is pretty good.", ""If we don't like something they would give us something else to choose from" and "the food is very good we don't have anything to complain about."

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in people's best interests. The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Staff we spoke with demonstrated an understanding of capacity and consent, and acting in people's best interests. They told us they always explained what they were going to do and gained people's consent prior to providing them with any care or support. This was confirmed to us by the people we spoke with.

The provider and their deputy demonstrated a knowledge and understanding of the MCA and DoLS and when an application was to be made to the authorising local authority. We were advised of a person for whom a recent application had been made and were awaiting allocation This was in relation to them being under constant supervision for their own safety. We saw documentation to show that best interest discussions had taken place with their next of kin so they were aware of the process and of the requirement to make an application in the person's best interests.

Staff told us they were provided with effective training which provided them with the skills and knowledge to undertake their roles competently. Newly appointed staff undertook a five day induction training course covering areas such as moving and handling skills, safeguarding people from abuse, first aid and medication training. They confirmed after they had completed the induction they shadowed experienced staff until they felt comfortable and had been assessed as competent to undertake their role safely. The induction covered areas relevant to the needs of the people who used the service and covered subjects which the provider deemed as mandatory. These included safeguarding, moving and handling, medication, health and safety, nutrition and hydration, equality and diversity and fire safety. Training records confirmed this. We also noted staff could access additional training that might benefit them. For example we saw that some staff had completed training in loss and bereavement, end of life care and dignity and respect. The deputy informed us that whilst staff had previously completed the skills for care common induction standards all staff were completing some additional training to bring them up to the standards required of the new care certificate. The Care Certificate is the benchmark that has been set for the induction of new healthcare assistants and social care support workers was launched from April 2015, replacing the current Common Induction Standards (in social care). Staff had started the additional training in May 2015 and it was anticipated they would all have completed the care certificate training by October 2015. We were informed all further new staff would be inducted according to the care certificate framework.

Good

# Is the service effective?

Staff told us they felt well supported and could meet with the provider or their deputy whenever they wanted to; they did not need to make an appointment as they both had an open door policy. Documentation within staff files showed they also received on going support in the form of supervisions and an annual review of their work. During these sessions they discussed what had gone well in their work, training and any future personal development needs. Staff files we looked at confirmed this although we noted staff appraisals were overdue. However, this was acknowledged and we saw an action plan in place which informed us staff appraisals had been diarised to address the shortfall.

The service maintained good links with health professionals such as Doctors, District Nurses, Physiotherapists, Chiropodists and referrals were made when required. Documentation within people's files showed people were supported to see appropriate health care professionals to meet their specific health needs. For example we noted in one person's care records that they had input from the tissue viability nurse in relation to their pressure area care needs and another individual had input from the community psychiatric nurse to support their mental health needs. Records of the visits and any actions taken were recorded and care plans updated where care needs had changed This ensured their needs were met effectively and they remained healthy and well.

Appropriate equipment was in place for people with poor mobility and for those who were frail and at risk of pressure area damage. These included pressure relieving mattresses, cushions and repose boots to prevent the risk of pressure sores and grab rails and walking frames to aid people with poor mobility.

Good

# Is the service caring?

## Our findings

People we spoke with were complimentary about the staff who worked in the home. People's comments included "The staff here really are very good…my daughter found the home by recommendation, I haven't really looked back they are very good." "They [staff] really do care and help us." "They look after me well, if I wasn't happy with anything I would tell X"

People were given appropriate information about the home and the facilities that were available to them when they came to live at White Hill Residential Home for the elderly. We saw a copy of the home's brochure, their policies and procedures and other printed information in the reception area of the home. We were informed these could be produced in large print or other formats to suit people's individual needs.

People were given choices as to how they spent their day, what time they wished to retire to bed and get up in the mornings as well as choices around what they liked to eat. People's choices were clearly recorded in their care and support plans.

People's bedrooms were personalised with items of memorabilia and they were encouraged to bring such items with them when they came to live at White Hill House. One person told us I brought a little bit of furniture with me." Another person told us they had brought their computer with them and the home had internet access which they were able to access. This meant they were able to continue to pursue their hobbies and interests and communicate with their friends and family.

People's right to confidentiality was protected. All personal records were kept secure and were not left in public areas of the service. Visits from health professionals were carried out in private in people's own rooms. We observed staff protected people's rights to privacy and dignity as they supported them during the day and personal care was carried out behind closed doors.

The service recognised the importance of a caring supportive environment which welcomed people's friends and families and actively supported them to continue to maintain relationships they had prior to moving into the home. One visitor told us they were always made to feel welcome and staff were supportive in assisting them to take their relative out and in helping them recently to take them on a family holiday.

Staff we spoke with were compassionate about the people they cared for and had built up a good rapport with the people living in the home in an extremely caring way, which extended to their relatives and visitors too. We were informed of a recent event in which staff had supported an individual to celebrate a birthday milestone with their family and people living in the home. The provider had captured the event in photographic form and presented the individual with a hard bound book of the occasion as a memorable keepsake. People told us staff always celebrated people's birthdays and one person told us "it certainly doesn't go amiss." They told us they were celebrated with everybody living in the home and extended to visitors and relatives too. This showed staff recognised and celebrated important events in people's lives in an inclusive, compassionate and caring way.

There were procedures in place in respect of end of life care. We saw documentation within people's files to show that people's end of life care had been discussed with them and/or their families. The records contained details about how they wanted their care to be provided, who they wanted involved and whether they wished to receive resuscitation. Resuscitation had been discussed with them, their GP and their family/ lasting power of attorneys where they had appointed one and was documented in their care plans. This was to ensure people were involved in making important decisions about their end of life care, treatment and support. This enabled staff to provide their care and support according to their last wishes. We were informed support from the district nurses and an outreach service from St Francis Hospice was available to the service to ensure a person's last wishes of being pain free were upheld, when required.

People we spoke with told us staff always knocked before entering their rooms and used their preferred names. They said staff respected their privacy and dignity whilst providing them with personal care and support and visiting health care professionals saw them in their own rooms.

Good

# Is the service responsive?

## Our findings

Documentation within people's care files showed their needs had been assessed prior to them moving into the home. This enabled people and their families/ representatives to discuss their health, social and personal care needs and ensured both parties were confident their needs could be met appropriately. The information was then used to develop an initial care plan which set out the care and support they needed in a personalised way. This meant staff were informed of people's needs and the level of support they required to meet their needs.

People told us they and/or their families were consulted with about their care and support needs and were fully involved in the development and reviews of their care and support plans. This was evident in the care plans we viewed which were personalised and clearly indicated people's individual needs, preferences and wishes.

People had signed consent forms to verify they had been consulted with in the care planning process, agreed to the contents of their care plans and consented to the home sharing information with relevant health and social care professionals where necessary. In situations where people did not have the capacity to contribute, best interest meetings were held which involved family or representative(s). Where people had lasting powers of attorney in place, this had been documented appropriately within people's care files.

The care plans we viewed were personalised according to people's individual needs, preferences and wishes. We saw they had been regularly reviewed to ensure they were up to date and met their needs accordingly. Where any changing care needs had been identified they had been documented in their care plan and communicated to the staff team.

Where people had physical or mental health needs, specialist care was provided. For example one person was under the care of a consultant to address their specific healthcare needs and another person had input from a community psychiatric nurse. Records of the visits and any actions taken were recorded and care plans updated where care needs had changed.

People's life histories had been documented and completed. These provided staff with a picture of the person's life history, their hobbies and interests and family connections. People told us they were supported to follow their interests and take part in social activities both within the home and within the local community. These included trips out to visit local places of interest, local theatres, art and crafts, cake making and decorating, music and film afternoons, hand massages and reminiscence sessions. This showed there were a variety of activities made available to ensure people were protected from the risk of social isolation.

There was a visiting manicurist, hairdresser, and podiatrist who people could make appointments with if they required such services. There was also a local vicar who visited the home to provide religious services and Holy Communion for those who wanted to take part. This ensured people's spiritual needs were met.

There was a complaints procedure in place which people had all been provided with a copy of which contained the process for raising a complaint and contact details including the local government ombudsman, CQC and the local authorities contact details. People were encouraged to raise any concerns with staff or the management team or could do so anonymously if they wished to via a suggestions/concerns box in the home or by voicing any concerns at the monthly forums. We were informed people generally raised any concerns informally with the staff or at the regular resident forum meetings and they were dealt with before they became an issue and subsequently a formal complaint. People we spoke with knew how to raise any concerns or complaints and who they would speak to if the need arose. Comments included "We don't really have anything to complain about" and "They look after us well I don't have anything to complain about." People were confident if they had any concerns they would be dealt with appropriately. The deputy told us they spent time 'hands on' alongside staff which meant any issues raised or observed could be dealt with immediately.

Any complaints were logged and documented appropriately, detailing the actions taken and the resulting outcome. We were informed there had been two complaints this year. We looked at the documentation and actions taken and saw they had been dealt with appropriately and within the organisations timescales. We saw appropriate actions had been taken and both had resulted in positive outcomes for the complainant. The deputy informed us complaints and concerns were analysed for any trends and fed into their quality assurance systems

Good

# Is the service well-led?

## Our findings

The service had a registered provider who lived on the premises and was responsible for the everyday management of the home. They had legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations. They were supported by a senior carer who was appointed as their deputy and a dedicated team of care staff. The deputy was undertaking leadership and management training and the provider informed us they were meeting with their deputy to discuss their personal development and their views and thoughts on taking on extra responsibility with the management of the home.

Staff told us they found the registered provider and their deputy approachable and they had no concerns in bringing any concerns to their attention. They described them as supportive and we observed positive and friendly interactions throughout our visit. They told us they worked together well as a team and felt the management listened to any concerns they raised and acted upon them.

People we spoke with told us they could speak with the registered provider and/or their deputy at any time; they did not need to book an appointment. It was evident through our visit that people who lived at White Hill House had built up good relationships with the registered provider and their team of staff and the atmosphere was very much one of an extended family. One individual informed us they had originally come to stay at the home for a period of respite with the intention of returning home. They told us they found the staff and management very accommodating and they had chosen to extend their stay on numerous occasions.

There was an open culture within the home and the provider and their deputy were keen to receive feedback on the care and services people received. These were sought on a day to day basis through general discussions and through regular monthly reviews of people's care. Annual questionnaires and monthly resident forums were also another means which provided people with an opportunity to give feedback on the service they received and raise any suggestions where improvements could be made. We saw an action plan in place which detailed the next questionnaires were to be sent out 31 July 2015. We looked at the responses from the last annual surveys which had been sent to families, residents, staff and health care professionals in April and May 2014. Only one response had been received from the health care professionals. This informed us they were satisfied with the overall care provided at the home and felt there was always enough staff. They stated they liked the overall homely atmosphere and were able to see their patients in private. We noted five questionnaires had been received from relatives, all of which had been positive. Comments included "The house is a cheerful place to be", "Lovely atmosphere", "Friendly family feel." and "You love your residents." There was one suggestion from one relative in which they highlighted they would like to see staff encouraging their relative to be more mobile. We noted actions had been taken in response to the suggestion and details were contained within their care plan highlighting to staff they were to encourage the individual to mobilise more.

The provider had further systems in place to monitor the quality and safety of the service provided and to ensure they consistently met the needs of people who used the service. These included regular internal audits of key activities including the care provided, an analysis of any accidents and incidents and any trends, an analysis of any complaints received and an audit of the management of people's medicines and finances. A recent fire risk assessment had been undertaken by an external health and safety consultancy the week before our visit and we saw appropriate records were held for weekly fire doors inspections, fire alarm testing and monthly call bell checks. Where any areas of concern were highlighted, action plans were put into place detailing actions to be taken and addressed within a specified time span and added to the home's on going service improvement plan. We looked at a copy of the on going improvement plan and found clear actions were documented detailing who was responsible for the actions and by when.