The Whitgift Foundation

Whitgift House

Inspection report

76 Brighton Road
Croydon
Surrey
CR2 6AB

Tel: 02087600472
Website: www.whitgiftfoundation.co.uk

Date of inspection visit:
24 March 2016
29 March 2016
30 March 2016

Date of publication:
01 June 2016

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

We visited Whitgift House on 24, 29 and 30 March 2016. The inspection was unannounced.

The service provides residential and nursing care for up to 36 older people.

The service 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 2008 and associated Regulations about how the service is run.

People at the service felt safe and secure. Staff knew how to recognise and respond to abuse and had completed safeguarding of vulnerable adults training. They knew how to report safeguarding incidents and escalate concerns if necessary. The service provided a safe environment for people, visitors and staff. People's needs were assessed and corresponding risk assessments were developed. There were sufficient numbers of staff to meet people's needs. Staff recruitment was subject to robust systems to ensure the service employed suitable staff. The management and administration of medicines was safe. The service provided care and treatment in a clean and hygienic environment.

Staff were supported with regular supervision and comprehensive training. The service was working within the principles of the MCA. We saw evidence of completed mental capacity assessments, best interests meetings and DoLS in care plans and care records. Staff had completed MCA and DoLS training. People were supported to have a healthy diet and to maintain good health.

People were consistently positive in their comments about staff. We observed numerous examples of positive interactions. People and their representatives were supported to express their views and were involved in making decisions about their care and treatment. Keyworkers provided additional support for people. There were meetings for people where they could express their views and opinions about the day to day running of the home. Staff respected people's privacy and dignity. People's preferences for end of life care had been considered with them and family and recorded in line with their wishes. The service was an accredited Gold Standards Framework (GSF) nursing home.

People received personalised care, support and treatment that focussed on their needs, goals and preferences. People were involved in the development of their care and treatment. Care plans and associated risk assessments reflected their needs and preferences. People were encouraged to take part in activities which reduced the risks of them becoming lonely, bored and isolated. There were regular meetings for people using the service to feed back their experiences of the service and suggest improvements or changes. People were confident that they could raise concerns with staff and those concerns would be addressed.

Staff spoke positively about the management team and said they were approachable. Staff meetings were held regularly giving staff the opportunity to feedback their thoughts about the service. There was a system of reviews, checks and audits to assess and monitor the quality of service provided and identify any risks to the health safety and welfare of people using the service, staff and visitors. Records relating to the provision of care were fit for purpose.

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 at the service felt safe and secure. Staff knew how to recognise and report abuse. People's needs were assessed and corresponding risk assessments were developed. There were sufficient numbers of suitable staff to meet people's needs. Medicines were managed safely. The service was clean and hygienic.

Is the service effective?

Good

The service was effective. Staff were supported with regular supervision and comprehensive training. The service was working within the principles of the MCA. People were supported to have a healthy diet and to maintain good health.

Is the service caring?

Good

The service was caring. People spoke positively about staff. People and their representatives were supported to express their views. Keyworkers provided additional support for people. Staff respected people's privacy and dignity. People's preferences for end of life care had been considered with them and family.

Is the service responsive?

Good

The service was responsive. People received personalised care, support and treatment that focussed on their needs, goals and preferences. People were encouraged to take part in activities which reduced the risks of them becoming lonely, bored and isolated. People were confident that they could raise concerns with staff.

Is the service well-led?

Good

The service was well-led. Staff spoke positively about the management team and staff meetings gave staff the opportunity to feedback their thoughts about the service. There was a system of reviews, checks and audits to assess and monitor the quality of service provided.

Whitgift 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 24, 29 and 30 March 2016 and was unannounced. The inspection was carried out by an adult social care inspector.

Before the inspection the provider completed a Provider Information Return. 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 reviewed information we held about the service. We spoke with eight people using the service and 12 members of staff including the management team. We carried out general observations throughout the inspection. We looked at records about five people's care and treatment which included care plans and risk assessments. We looked at three staff files and reviewed records about medicines, policies and procedures, general risk assessments, complaints and service audits. We consulted three health and social care professionals for general feedback about the service which was positive.

Good

Is the service safe?

Our findings

The service was safe. We spoke with people using the service who told us they were safe. For example, one person told us, "It's very nice here, I'm quite lucky. I feel perfectly safe." Another person said they were, "Safe and secure." We spoke with members of staff about safeguarding. They were aware of their personal responsibilities and knew how to recognise, report and escalate safeguarding concerns. We checked staff training records which confirmed staff had received training and refresher training. The service had policies, procedures and guidance covering safeguarding and whistle blowing. We also saw noticeboards contained advice and contact numbers about safeguarding and reporting concerns.

There were handovers between staff at each shift change. We observed the morning handovers for both floors. All members of the morning shift were present for the handover by the night duty nurse. The nurse provided a verbal report about each person using the service describing their well-being and behaviours overnight. The morning staff were attentive and most made notes about what they were told. They joined in with discussions about individuals generated by the night nurse's comments. The handover was overseen by the Matron. We were satisfied that staff started their shift appropriately briefed and up to date about people on their floor.

We found the service provided a safe environment for people using the service, visitors and staff. Although building works to improve and extend facilities had been taking place for some time the inconvenience to people had been kept to a minimum. Areas where building work was taking place were safely screened off. We carried out a visual inspection of the part of the building in use, the exterior of the building, gardens and equipment used to deliver care and treatment. All parts of the building and gardens were well maintained. The service had support from the provider's estates team and an onsite maintenance team of five including an electrician and a gardener. We examined various items of equipment, including hoists, baths, bathroom chairs, and found they were maintained at appropriate intervals and kept clean.

There was a personal emergency evacuation plan for each person using the service. Staff were trained in fire safety and knew what to do in case of a fire or other emergency. There was specific training to use fire evacuation sledges and the fire evacuation lift. The fire alarm system was checked regularly and periodic fire evacuation practices took place. Fire safety equipment, such a fire extinguishers and fire blankets were checked and maintained.

People's care and treatment was underpinned with a framework of risk assessments that helped staff to identify and meet people's needs. These risk assessments and risk assessment tools assessed the levels of risk in a wide range of areas and provided staff with guidance about how to deal with those risks. We looked at risk assessments in care plans and saw they covered areas such as skin integrity, falls, nutrition, moving and handling, electric heaters and bed rails. The risk assessments provided clear and concise information that supported staff to provide safe and appropriate care and treatment.

We found there were sufficient numbers of suitable staff to meet people's needs. We checked duty rotas and

the staff on duty matched the rota. On the early shift, people were supported by two registered nurses and 10 care assistants that reduced to two nurses and eight care assistants for the late shift. At night time there was one registered nurse and four care assistants. The maximum number of people the service was registered for was 36 and at the time of our inspection there were 35 people using the service.

Two activities coordinators, maintenance, catering and domestic staff provided additional support during the daytime. On most days of the week the manager, deputy or clinical lead was working. The manager and clinical lead were both registered nurses. The rotas ensured there was a mix of experience and leadership among the care workers on each shift. Planned absences were accommodated through the staff rota and short notice absences by staff on duty and bank staff. The service rarely used agency staff and that was only for nursing cover. The service always used the same two agencies and requested nurses who had worked at the service before.

We examined a random selection of staff files for nurses and care assistants. All of the staff files had been recently audited and brought up to date. They clearly showed there were robust procedures in place to ensure the service employed suitable staff. Each file showed staff had received enhanced clearance through the Disclosure and Barring Service. (These important checks identify people who are barred from working with children and vulnerable adults and inform the service provider of any previous criminal convictions). Staff annually completed a declaration about their criminal record status. They also included copies of identification documents; an application with a work history; an interview record; and two references. There was a check with the National Medical Council to ensure nurses were registered.

Medicines, including controlled drugs, were safely managed and securely stored in appropriate conditions. We examined records of medicines received, administered, disposed and looked at a random sample of medicines held against records and did not find any discrepancies. Registered nurses administered medicines and they retained the keys throughout their shift. We observed nurses safely giving medicines to people and saw records were completed at the time. The nurse administering medicines wore a red tabard indicating they should only be disturbed in emergencies which reduced distractions and decreased the likelihood of medicine's errors. Any allergies were clearly identified to the nurse administering medicines in red.

Medicines policies and procedures were available to support staff. There was GP guidance about the administration of pro re nata (as required) medicines such as Paracetamol. Administration of pro re nata medicines and topical creams were clearly recorded. Some people were self- medicating and where this was the case a risk assessment had been completed. Where people were taking medicines that required regular medical checks this was referred to in medicines records and care plans. For example, we saw past and future appointments at anti-coagulant clinics for people taking Warfarin. Medicines were reviewed by the GP annually or in response to changes in people's needs.

We found people's rooms and communal areas and facilities were clean and tidy. The service was following the Department of Health Codes of Practice for the prevention and control of infection in care homes. We spoke with the housekeeper who told us there were four cleaners on duty and one member of staff assigned to ironing duties. Cleaners worked every day of the week. We spoke with a cleaner who told us their equipment was always up to date and well maintained. They were aware of the cleaning products they used and how to store them. We checked bathrooms and toilets on both floors. The floors, walls, tiling, toilet pans, baths and shower arears were spotlessly clean. All staff had ready access to a plentiful supply of personal protective equipment and nurses, care assistants and domestic staff were provided with uniforms.

The housekeeper was aware the Codes of Practice had been updated last year. There was a cleaning

schedule and one or two bedrooms received a 'thorough' clean each day where all items in the bedroom were moved to enable areas to be cleaned or polished. There was a rolling programme to remove and clean the curtains in each bedroom. The service met the requirements of the Control of Substances Hazardous to Health Regulations (COSHH). Such substances were stored in locked COSHH cupboards situated in sluice rooms. Domestic staff were provided with training and guidance in the use of these products.

Good

Is the service effective?

Our findings

We found staff were supported with regular supervision meetings and training. There were clear lines of supervision and everybody was clear about who was responsible for providing supervisions for them. There was also an annual appraisal. These supervision meetings provided management and staff with the opportunity to discuss performance, training and development needs, concerns and for staff to feedback about the service. A member of staff said, "We have regular supervisions, an appraisal, we can speak freely."

In terms of training, one member of staff told us, "[The trainer] never leaves you alone, we are always training." Another said, "If you want additional training you just ask." One member of staff told us, "I wanted to do palliative care and they gave me the training." The service benefitted from the employment of a well-qualified full time trainer. The trainer often provided training at unusual hours to ensure staff working at night were supported with the same level of training as other members of staff.

In addition to ensuring a programme of mandatory training and refreshers were completed by staff the trainer regularly engaged staff on duty with impromptu training and competency assessments. There was additional training in specific areas. For example, in addition to dementia awareness the service brought in external training on 'Virtual Dementia' for some members of staff. This training used specially designed equipment so that staff could relate to some experiences a person living with dementia might have.

The completion level of staff training at the service was exceptional. Our examination of training records showed staff completion of a wide range of relevant training topics was extremely high. The only gaps in training related to more recently employed members of staff who were in the process of completing their inductions, some of whom were completing the components of the Care Certificate. (The Care Certificate explicitly identifies the learning outcomes, competences and standards of care expected in health and social care).

Staff were able to complete further training and qualifications. Staff were supported with appropriate qualifications such as those obtained through the Qualifications and Competencies Framework (QCF) which is the national credit transfer system for education qualifications. For the last year, the service has run a small series of workshops to support nurses with their revalidation requirements and as part of their continuing professional development. The service has also started team leader workshops. In our conversations with staff we were impressed with their overall knowledge including specific topics we raised such as safeguarding and mental capacity.

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 and found they were. We saw evidence of mental capacity assessments, best interests meetings and DoLS in care plans and care records.

Staff were aware of the dietary needs and preferences of people they cared for and care records confirmed a suitably balanced diet was provided to promote people's health and well-being. Care records included risk assessments to identify if people were at risk of malnutrition. Meals and fluid charts were maintained to ensure people were receiving sufficient amounts. Care plans included a section on nutrition and hydration. Where people had problems they were referred to appropriate professionals such as the GP, dietician, and speech and language therapist. Meals were served in the dining room, dining areas and people's rooms. One person told us, "The food is very nice." We confirmed that snacks and various drinks were available to people outside of meal times. We observed people, whether in communal areas or in their rooms, had ready access to drinks. People requiring assistance when eating or drinking were supported by staff who chatted with them and explained what they were doing. There was no pressure to complete meals in a set time and for most people meals were an enjoyable part of the day.

People were supported with their healthcare needs. A range of healthcare professionals visited the service to provide advice and care for people. Staff arranged for these visits and where required supported people with external appointments. There were monthly visits from the chiropodist. We saw records of visits to the optician, dentist, physiotherapist, GP and hospital. There were monthly clinical observations recorded including people's weight. We saw referrals to appropriate healthcare professionals such as the tissue viability nurse and the speech and language therapist (SALT). In one care plan we saw the SALT referral, subsequent report and the guidelines provided to staff in relation to the person's dysphagia (difficulty swallowing). Everybody at the service had hearing assessments as the result of a project being run by the Croydon Hearing Centre. They also ran a series of hearing awareness workshops for staff to develop their skills in examining people's ears; hearing impairments; the mechanics, maintenance and use of hearing aids; referrals; and, for nurses otoscopy.

Good

Is the service caring?

Our findings

Care was delivered by staff in a patient, dignified and friendly manner. One person using the service said, "As I need a rest home I couldn't do better. They go the extra mile and they are personable. We are not seen as anything but a full human being." Another person told us, "I'm very happy with the staff. It's the best home in Croydon." One person said, "Staff are kind. I'm happy here." A member of staff told us, "I love my job, the residents are lovely, I really enjoy working here." Another said, "People are treated as equals." One member of staff said, "If we have any spare time we sit and chat with a resident or have a cup of tea with them."

People were consistently positive in their comments about staff. We observed interactions between people and staff in a variety of situations. At times staff were aware they were being observed, on other occasions they did not. Sometimes we remained out of sight and listened to what was happening. At no time were we aware of any negative interactions. In a few instances there was some neutral interactions but most of the time they were positive.

Each person was assigned a key worker when they moved into the service. The keyworker was a main point of contact for the person, family and friends with responsibilities for their continued care and welfare. In meeting those responsibilities the keyworker established friendship and trust and got to know people's likes and dislikes. They also obtained goods and services on their behalf as and when required such as purchasing specific items requested. The keyworker was involved in developing and updating care plans and risk assessments to meet people's needs and preferences based on their enhanced knowledge of the individual. People knew their keyworkers and care records clearly recorded them. People were also assigned a named nurse

People were supported to express their views and were actively involved in making decisions about their care and treatment. We saw evidence in care planning of people's involvement. Those who were able consented to their care and treatment and signed to that effect. Monthly reviews were signed by people to show their involvement in the process. If they so wished they could have family or other representatives present to provide additional support. We saw one example where the service requested the help of a family member to explain and help the person fully understand certain elements of their care and treatment.

Staff treated people with dignity and respected their privacy. Care plans reinforced to staff the need to deliver care and treatment with dignity. The home had identified dignity champions within staff, including the matron, to promote good practice. All training sessions reinforced the importance of dignity. We found staff spoke to people in a friendly and polite way. Staff addressed people by their preferred name. When completing care and treatment staff explained what they needed to do and what they were doing. People were asked not told. Privacy was respected. Personal care and discussions about care and treatment took place in private.

We saw people's preferences for end of life care had been considered with them and family and recorded in line with their wishes. People who preferred to do so could be supported to spend their final days at the

service. One person told us, "I am very lucky to be here. I have had a wonderful life and hopefully a wonderful death here. The staff are very kind."

The service worked closely with St Christopher's Hospice and the GP to ensure people's wishes were prepared for and met. Staff were supported with appropriate training and guidance. Staff were encouraged to attend training opportunities provided by St Christopher's. The service was an accredited Gold Standards Framework (GSF) nursing home. (GSF is a framework to help deliver a 'gold standard' of care to people as they near the end of their lives). The service achieved GSF 'beacon' status which was the highest level of GSF accreditation.

Good

Is the service responsive?

Our findings

People received personalised care, support and treatment that focussed on their needs, goals and preferences. We looked at care plans and saw they were written in a person centred way and addressed a wide range of people's needs. The care plans also contained relevant risk assessments for each person and focussed on people as an individual. Care planning was based on information received on admission and discussion with the individual, family, keyworker and other relevant members of staff. Care planning was a continuing process that adapted to new information and changes in people's health and social care needs and preferences. We saw many examples in people's care plans that were specific to individuals in response to their needs.

We found people's life histories were recorded in detail in their care plans. This enabled staff, particularly at the beginning, to be aware of subject areas and personal information they could talk about to put people at ease and make them feel more at home. In certain cases, the history might explain specific behaviours. We found one lengthy history in care plans and spoke to the relevant person. The history was accurate and clearly reflected the person we were speaking to.

To minimise the chances of loneliness, boredom and social isolation there was a range of formal and informal activities available to individuals and both small and large groups. The service employed a full time and a part time activities coordinator. The service had a minibus that was used to take people out on trips. The Friends of Whitgift met four times a year and arranged a summer garden party for people and guests. They also provided volunteer drivers.

We were made aware of and observed regular activities for people using the service. These included physical exercises, art and crafts, music, classical music including a concert once a term, regular trips to the garden centre, a book club, Evensong once a week and regular visits from children from three local schools that were part of the Whitgift Foundation. In better weather some people enjoyed croquet. There were weekly visits by a nail bar and a hairdresser. There were celebrations for birthdays and especially people reaching birthday landmarks. There were some Namaste sessions involving hand massage, nail painting and music for people on palliative care. When possible the activities coordinator sat with people who could not attend group activities.

On one day of the inspection we observed a classical music group in the upstairs lounge that was well attended. We spoke with one person sitting in a quiet area on her own looking on to the courtyard. They told us they preferred sitting there or reading their books. They knew there were activities but chose not to go to them. They were told what activities were happening each day but there was no pressure to attend.

On the first day of our inspection there was a meeting for people using the service that gave them an opportunity to feed back their experiences of the service and suggest improvements or changes. Previous meetings had resulted in three new types of drinks glasses being introduced and on another occasion a request for egg spoons being met. The meetings were also used to update people about what was

happening such as the progress of building works. The service sent out an annual questionnaire to people using the service. It was noted that there was a very high percentage of returns from people using the service who provided positive feedback.

People could also feedback their experiences through their keyworkers or members of staff in general. People told us they spoke to staff if something was not right or was bothering them. The Matron carried out 'ward rounds' twice a day to ensure she was a familiar face to people, visitors and staff. The deputy manager and clinical nurse lead were also regularly seen throughout the service. There was a complaints process for formal complaints. These were usually dealt with by the Matron. The complaints process reflected recognised good practice in relation to acknowledgements and responses. All complaints were overseen by senior management to ensure they had been dealt with appropriately and to identify any learning opportunities or areas for improvement.

Good

Is the service well-led?

Our findings

The service was well-led. One member of staff told us, "I really like it – much, much different to previous homes I have worked in. Here is really professional, people are treated as equals. The management treat us very well and we treat the residents very well." A newer member of staff said, the senior staff and the general staff are very supportive." The Matron was a registered nurse and experienced manager and was appropriately registered with the Care Quality Commission. The Matron was supported by a deputy manager and clinical nurse lead. We checked the website for the service and found it accurately portrayed the service provided.

The provider fully supported a culture of openness and transparency with people using the service and their relatives or representative. To that end there was a Duty of Candour policy for the service that stated, "The organisation believes that being open and promoting a culture of openness and truthfulness is a prerequisite to providing safe, high-quality care." It continues, "[The organisation] believes that, in the event of these standards not being met, it should apologise sincerely to the service users concerned and provide a full explanation as to what went wrong and why." In our conversations with staff they were confident they could raise concerns and report incidents, errors and accidents to supervisors and they would be dealt with appropriately.

We found there was a framework of team meetings that provided a two way forum to provide staff with information and for staff to feedback experiences and make suggestions. Every month meetings were held for care staff, nurses, and housekeeping. There was also a monthly team meeting that involved management, administration and the training and activities coordinators. Every two to three months there were meetings for senior care assistants and for senior nurses. Staff and relatives were sent a survey at the same time as people using the service. Surveys were analysed and summarised and fed back to participant groups.

Accidents and incidents were clearly recorded in an Accident Book. The accident recorded a summary of the accident or incident, actions taken in response and further actions taken. Each accident or incident was reviewed by the Matron to ensure appropriate action had been taken and to identify any learning or opportunities for improvement at service level or provider level. We examined our records for the service and found that statutory notifications were submitted as required and in a timely fashion and the occurrence of these incidents were within normal parameters for comparable services.

Checks, reviews and audits were regularly undertaken to assess and monitor the quality of the service provided and to identify any risks to the health, safety and welfare of people using the service, staff and visitors. For example, nurses checked medicines when they came on shift. There were regular checks by the maintenance team and planned maintenance by external companies for equipment such as hoists and fire alarms. Care records were reviewed on a regular basis. Medicines were audited monthly by the clinical nurse lead. The Matron completed monthly reports about all aspects of the service for submission to the provider. The Chief Executive visited regularly and checked different areas of service provision and fed back his

findings to the Matron. We discussed with the Matron the value of those visits being formally recorded and the value of external audits.

In the course of our inspection we examined records completed in the carrying on of the regulated activities. We found records were readily accessible, up to date and relevant. Staff were familiar with records and, in response to our requests, were able to show us where records were kept for specific aspects of care and treatment. Where appropriate records were stored securely. Care records and staff files, for example, were only accessible to those people who needed and were authorised to see the contents.