London and Manchester Healthcare (Whittle Hall) Limited

Whittle Hall House Care Residence

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

Summary of findings

Overall summary

This inspection took place on 17 May 2018 and was unannounced.

Whittle Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Whittle Hall accommodates 74 people across three separate units, each of which had separate adapted facilities. One of the units specialises in providing care to people living with dementia. The other two units specialise in supporting people with nursing needs and dementia.

At the time of our inspection there were 43 people living in the home.

Whittle Hall is owned and run by London and Manchester (L&M) Healthcare, specialist providers of luxury care residences with particular emphasis on general nursing and dementia nursing care.

A registered manager was in post.

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.

Staff were aware of the reporting protocol to keep people safe from abuse or potential harm. Staff could clearly describe in what instances they would raise concerns and knew what the characteristics of abuse were.

There had been a number safeguarding concerns raised with the local authority and incidents with relation to falls. We checked the procedure for falls management, including recording and reporting the fall appropriately, analysing records for patterns, trends, or any re-occurrence that would warrant further investigation and referrals. We saw the service was doing this, and in some cases, additional investigations into incidents were being conducted.

There were no open safeguarding investigations at the time of inspection. We discussed how improvements had been made from historical safeguarding concerns including the opportunities for lessons learned.

Staff were recruited and selected to work at the home following a robust recruitment procedure. The registered manager retained comprehensive records of each staff member, and had undertaken checks on their character and suitability to work at the home.

Risk assessments were in place and were reviewed every month or when there was a change in people's needs. We saw risk assessments in place to manage people's mobility needs, falls, pressure areas, personal care, mental health and behaviour. Risk assessments were linked to an accompanying plan of care which was informative and fully described how staff were required to support the person.

We saw that rotas were fully staffed; There were some agency nurses being used, however, most of the agency staff were used regularly. This meant that they were familiar with the home. The registered manager had a process in place to recruit new staff and we saw that some new staff were due to start working at the home.

Medication was managed, administered and stored securely by registered nurses or senior advanced practitioners on each unit. Each person had a medication file in place which contained information about them and their preferences for taking medication.

There were domestic staff around the home ensuring that rooms and bathrooms were kept clean. There was hand gel available around the home and personal protective equipment (PPE) for staff to use to prevent the spread of infection.

People's needs and choices were assessed prior to them being admitted to the home.

The training matrix showed that staff were trained in all subjects which were mandatory to their role, and as stated in the registered provider's training policy. We saw that additional training was sourced into the home by an external provider which was specialist around communication and supporting people with dementia and limited engagement. We were given an over view of this training. Additionally, opportunities were provided for senor staff to complete additional courses which enabled them to complete more clinical tasks.

Staff received regular supervision and appraisal.

People were supported to eat and drink in accordance with their needs. People, who were assessed as at risk of weight loss, had appropriate documentation in place to monitor their food and fluid intake. Where specialist diets were needed for some people, the chef had knowledge of this.

The service was operating in accordance with the principles of the Mental Capacity Act, 2005 (MCA). Applications to deprive people of their liberty had been appropriately made following best interest decisions.

The environment was exceptionally well decorated and appropriate for people living with dementia. There were different coordinating colours on the dementia unit, and a large living wall mural which appealed to people's senses of touch.

Staff were observed to be caring, kind and knowledgeable concerning the people they supported. Our conversations with staff evidenced that they knew people well, and supported them in caring and dignified way

There were positive examples of person centred information in peoples care plans. People likes, dislikes and routines were well recorded and regularly reviewed.

There was a varied and relevant timetable of activities offered at the home. Public events, such as the

upcoming royal wedding had been well planned and there were various activity 'stations' around the home which contained objects of reminisce, fiddle muffs and creative drawing.

Complaints were well recorded, addressed and responded to in line with the organisations complaints procedure. This was also available in different formats to support people's understanding of the policy. Additionally, there was information around the home which clearly described the complaints process and whom people should raise concerns with.

There was a robust approach to governance within the home. The quality and compliance director spent time describing the process of quality assurance within the organisation and how this improved service provision and in turn, people's experiences of living at the home.

People's views and opinions were regularly acted upon. In addition to feedback being gathered from people and their relatives, there was also a 'you said we did procedure'.

The service was working well with local stakeholders by ensuring that actions set at recent monitoring visits were addressed.

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.

Risk assessments were accessed and reviewed as part of people's care needs, these were detailed and gave staff clear instruction of how to manage and minimise assessed risks.

Our observations showed there was enough staff to meet people's needs in a timely way.

Medicines were managed safely and stored appropriately. Medication was only given by staff who were trained to do so.

Staff were only offered employment once suitable pre-employment checks had been carried out which included an assessment of their suitability to work with vulnerable people.

Is the service effective?

Good

The service was effective.

The staff had the correct training to reflect their roles; this was evidenced in the training matrix.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service was working in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

We observed kind and familiar interactions between people who lived at the home and the staff who supported them.

Staff were able to demonstrate a good knowledge of the people they supported.

There was advocacy information available for people who wished to access this service.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People received care which was right for them, which took into account their backgrounds, needs and wishes.

Complaints were appropriately responded to and documented in line with the service's policies and procedures.

People were supported sensitively with arrangements for end of life care.

Is the service well-led?

Good

The service was well-led.

The registered manager was well regarded by people receiving care and staff.

Audit processes were sufficiently robust to identify issues of concern.

Team meetings and resident meetings took place.

There was evidence of positive working relationships with local stakeholders.

Whittle Hall House Care Residence

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 in part by information we received early in the year from the Local Authority contracts team. who had previously They had raised some concerns with the registered provider with regards to service provision. Before our inspection we contacted the contracts team who provided feedback which was largely positive about the home and improvements which had been made in last few months. We were assured during this inspection that efforts had been made to address these issues and this was confirmed by the Local Authority contracts team.

This inspection took place on 17 May 2018 and was unannounced.

This was the registered provider's first inspection.

This inspection was conducted by three adult social care inspectors and a Specialist Advisor whose area of specialism was nursing care and medication.

Before the inspection at Whittle Hall we reviewed all of the data and intelligence we had gathered about the home. We had not yet requested a provider information return (PIR) for this service. A PIR 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. This included information the Care Quality Commission had received about the home.

We spent time talking to people's relatives. Some of the people who lived at the home could not engage in conversation with us to share their experience of living at Whittle Hall. We carried out a Short Observational

Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

In addition, we checked the care plans and associated records for eight people, including five people's medication records. We also spoke five visiting relatives, 11 staff including the registered manager, compliance and quality and compliance director, deputy manager, nurse in charge, chef, maintenance person, and other staff members. We carried out observations in the communal areas of the home, and had lunch with people who lived at the home to share their dining experience.

Good

Is the service safe?

Our findings

We spoke with visiting relatives who raised no concerns with regards to the safety of their family members. Comments we received included, "I have no concerns," Relatives and staff also commented that the home has felt 'safer' and 'improved' since the new manager took post.

There had been a high number of safeguarding's at the home in last few months. We spoke to the registered manager concerning some of the safeguarding's and any recommendations or 'lessons learned' as a result of these. One of the issues which was identified was the lack of consistent staff, so a plan was implemented to recruit permanent members of staff.

The registered manager was transparent concerning some staff issues which had been an historical problem in the home since it opened last year. We saw however, that the number of different agency staff being utilised had decreased in the last few months, and the home had a full staff team of carers. Some agency nurses were still being utilised, however, the registered manager explained that they tried to 'block book' the same agency nurse to ensure consistency.

We discussed safeguarding procedures with staff who worked at the home as we wanted to check they knew the correct process if actual or potential abuse was reported. Staff clearly described how they had a duty to report concerns and said how they would not hesitate to 'whistle blow' to external organisations such as CQC or the local authority. A whistle-blower is an employee that reports an employer's misconduct. There are laws that protect whistle-blowers from being fired or mistreated for reporting misconduct.

Medicines were administered individually from the trolleys to people living at the home. Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range. We saw there was a thermometer on the wall where the trolleys were stored. Checking medications are stored within the correct temperature range is important because their ability to work correctly may be compromised.

Some people were prescribed medicines only to be taken when they were needed it (often referred to as PRN medicine) People had a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people became upset or anxious.

The medication administration records (MAR) included a picture that was sufficiently large enough to identify the person. We noted that the MAR charts had been completed correctly and in full.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Some people were prescribed topical medicines (creams). These were stored safely and body maps were routinely used to show where topical creams should be applied.

We saw that one person was taking their medication covertly. This means that the medication was disguised

in food or drink to support the person to take it. Anyone subject to covert medication has to have a best interest decision in place which sets out why this is needed, as well as accompanying information from the GP and pharmacist. We saw from checking this person's information that all documentation was in place to ensure this medication was administered safely.

We looked at how incidents and accidents were managed at the home. We saw that there was a process in place to analyse the number of incidents which occurred over the month. There was also consideration given to time of day of incidents and staff on duty. We saw that some reoccurring incidents had been investigated further and additional referrals were made as a result of this.

Staff records we saw demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work. The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the registered manager to assess their suitability for working with vulnerable adults. This shows there were safe procedures in place to recruit new members of staff.

Clinical risk assessments for people living at the home were concise and clearly written. People who were identified as being at risk of skin breakdown or falls had documentation in place to ensure staff were supporting them to manage their condition. Some of the risk assessments we viewed contained detailed information with regards to how to mitigate risk. For example, 'ensure person has their pressure mattress set on the correct setting of xxx'. Also, 'Staff are to check pressure areas daily and report any areas of concern to nurse on duty.'

People who were at risk of falls had up to date information recorded in their care plans with regards to how to ensure they were not at risk of falling, or the risk of falling was minimised, such as 'ensure person has their zimmer frame to hand when they are sitting in their chair' and 'ensure alarm mat is plugged in.' We observed people who required alarm mats had them plugged in both in their rooms and when sitting the in the lounge areas. This meant that staff had followed instructions in peoples care plans with regards to how to support that person remain safe.

We saw that all firefighting equipment had been checked and new equipment was in place in various parts of the home to help people evacuate safely. Personal emergency evacuation plans (PEEP's) explained each person's level of dependency and what support they would require to ensure they were evacuated safely. We spot checked some of the other certificates for PAT (portable appliance testing), electric, gas, and checks on the other equipment such as the hoists. These were all in date. We saw that fire doors were in working order, and there were key coded exits and entrances for the nursing unit and the dementia unit in order to ensure people who were at risk of absconding were kept safe.

We checked the process for preventing the spread of infection in the home. The home was odour free, clean and there were hand sanitizers on the walls. Sluice rooms were kept locked when not in use and staff wore personal protective equipment (PPE) such as aprons and gloves? when supporting people with personal care.

Good

Is the service effective?

Our findings

Visiting relatives we spoke with said that the staff have the correct skills and knowledge to support their family members. Comments included, "They know what [family member] needs," and "They are very good with [Family member]."

We saw that people were assessed prior to them being admitted to the home. The initial assessment process focused on people's needs and choices while taking into account the type of treatment and support they required. This had been transferred and incorporated into the person's care plan. For example, 'Encourage [person] to do as much as possible for themselves.'

The training matrix and examination of staff training certificates showed that all mandatory training was in date, and had been completed by staff. Training took place in a range of subjects including moving and handling, safeguarding, first aid, health and safety and mental capacity and deprivation of liberty safeguards (DoLS). We saw that specialised training was taking place to support people living with dementia and how to communicate with people. We were provided with an overview of this training as it took place on the day of our inspection. The training was completed by an external training company. In addition, staff completed training in Management of Actual or Potential Aggression (MAPA). This ensured that staff had the correct skills to support people when they were displaying behaviours which could be deemed as challenging.

Staff we spoke with confirmed they received regular supervision and appraisal. The induction process for staff who had no previous experience of working in health and social care settings was aligned to the principles of the Care Certificate. The Care Certificate is a 12 week programme designed to help newly appointed staff working within the health and social care sector develop their skills within the role. This can then be signed off by a senior colleague when completed. In addition, the registered provider had their own induction which all staff were required to complete. This included discussions around polices such as whistleblowing, safeguarding and equality and diversity. All staff who had been working at the home for more than six months had been enrolled onto the relevant NVQ qualification. In addition to this, senior support workers were given the opportunity to complete accredited training to enable them to become senior advanced practitioners. This would mean that the care staff were able to complete more clinical tasks for people once they had been trained, which in turn would help support people more efficiently with their needs. This training was overseen by a professional and was accredited by a recognised institute. There were also other training opportunities in the near future which would be offered to staff at Whittle Hall. This shows the provider in encouraging the staff to develop and supporting them learn new skills.

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 decision's and are helped to do so when needed. When they lack mental capacity to make 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).

The service was working within the principles of the MCA. Additionally, we checked to see whether the conditions identified in the authorisations to deprive a person of their liberty were being met. The registered manager was knowledgeable about the MCA and DoLS and knew the CQC needed to be notified when the outcome of any applications were known. We saw that some people had conditions stipulated on their DoLS authorisations and these conditions were subject to continuous checking.

We saw that 'best interest processes' were being followed for people who had limited capacity and understanding of complex decision making. The need for 'best interest' processes were clearly identified in people's support plans. The service had documentation in place which encouraged people to be involved in the decision making process in a way that they understood. For example, we saw some people required bedrails to be in place. The bedrails risk assessment was presented in a pictorial format with simple questions to check people's understanding of the reasons why they required bedrails. This shows that the service is actively encouraging people to partake in decisions around their own care by presenting information in different formats to support people's understanding.

The home was decorated to an exceptional standard. The dementia unit was clearly adapted to support people to orientate their way around. Each door was painted a different colour and there was contrasting brick wall paper on the corridors to contrast the doors. Corridors were wide to enable people to safely walk up and down, and on each section of the unit was objects of reminiscence, such as a 'fish and chip beach hut area'. In the dining room was a living wall mural which had been specially designed to help appeal to people's senses of touch and hearing. The staff were exceptionally proud of this and told us they had recently won an award for art installation of the year for the 'Living Wall'. In addition the home had also won an award for the best 'Collaborative Estate and Facilities Team Project' for Dementia Plus. This shows that the service is being recognised for its adaptation and design to support people living with dementia.

We observed the lunchtime experience and ate lunch with people who lived at the home. Food was plentiful and served to exceptionally high standard. Each place setting was equipped with matching crockery, table cloths, napkins and wine glasses. People were supported to choose what they wanted for lunch and could have any beverage they wanted, including wine or beer.

The chef had a good knowledge of people's dietary requirements and was able to explain how the menus were compiled so people had the chance to each choose a main meal. At the time of inspection, we saw that one person's choice of 'fish pie' was being served as the main course.

People were supported to access medical care when they required it. Each person had a health record in their care plan detailing their appointments with GP's, Tissue Viability Nurses, Opticians and Chiropodists.

Good

Is the service caring?

Our findings

Visiting relatives spoke positively about the staff at Whittle Hall. One relative said, "They (staff) are wonderful." Throughout the duration of the inspection we observed kind and caring interactions between staff and people who lived at the home. One person said, "Nothing is too much trouble for the staff."

Our observations at lunch time showed that people were being treated with compassion and dignity. Staff were helping people to reach their napkins to wipe their mouths, and asking people what drinks they would like with their meals. When we walked around the home at various parts of the day, we saw that people's bedroom doors were closed when they were being supported with personal care, and staff were addressing people respectfully. One staff member asked someone if they would like a sun hat to wear while they sat in the garden. Staff had time to sit and chat with people, and we saw people being actively encouraged to partake in activities and conversations.

There was a process in place to take care of people's clothing and belongings. We saw that lost items of laundry were kept in one place so people and their families could easily claim these back. Everyone looked clean and well cared for at Whittle Hall.

Care plans and reviews evidenced that people had been involved, and where possible had signed their own care plans or their relative had done this on their behalf if they were legally allowed to do so.

Care plans reviewed were written in way which took the person's choices and diversity into consideration. For example, how people liked to be dressed each morning, when they liked to get up, and how they wanted their personal care needs to be met. One care plan stated, 'Person likes to get up at 8 o'clock'. Also, 'Please ensure there is a jug of juice available in the person's room, as they do not drink hot drinks'.

We asked the staff how they ensured people's dignity and privacy was protected and staff told us they made sure they closed doors and windows before helping people undress or wash. We saw that the room which held people's confidential information was kept secure throughout the duration of our inspection.

We saw that positive reviews had been left on a national site about the home. One reviewer commented on their experience of Whittle Hall as 'Excellent throughout'. Another person said, 'You can leave here knowing your loved one is safe, warm and well cared for.'

There was information provided for people with regards to the local advocacy agency in Warrington. There was no one making use of this service at the time of our inspection.

Good

Is the service responsive?

Our findings

The care records that we viewed were sufficiently detailed to instruct staff and contained person-centred information. 'Person centred' means care which is based around the needs of the person and not the organisation. In one record we viewed there was a good level of detail about; family history, life history, medical history, likes and dislikes. This helped staff to get to know the person and provide individualised care which was responsive to the person's needs. One care record relating to a person with complex healthcare needs provided detailed guidance for staff, but also focussed on their personal preferences. For example, we saw that one person had right sided weakness which affected them when they transferred, there was great emphasis in helping the person choose appropriate footwear to support them with this.

We saw that people were getting the care and support which was right for them and specific to their assessed needs. For example, people who were at risk of developing pressure sores had an appropriate turning regime in place which had been completed accurately. Additionally, people at risk of weight loss or malnutrition were weighed regularly and where there had been a recorded weight loss the appropriate referrals had been made to dieticians. People who were diabetic, had appropriate care plans in place to incorporate regular foot care checks. This is because people who have diabetes are more at risk of having problems with their feet.

People were referred to dieticians and the Speech And Language Therapy (SALT) team when needed. We saw that one person had been put on a regime which required them to be weighed weekly and their weight to be monitored. We checked the persons records and saw they were being weighed, and their weight was consistent.

We saw how one person was supported with their cultural and religious choices whilst living at the home. This person was supported to maintain their diet in line with their religious beliefs. This shows that the service was respecting and encouraging people's diverse needs and human rights.

There was end of life training programme for staff to ensure that people were subject to a dignified and pain free death. The registered manager of the home was an external assessor for the Gold Standards Framework (GSF) which involved them visiting other homes to ensure their practice was sufficient. Therefore, they had a good knowledge of this area of care. People's wishes for end of life were documented in their care plans.

We checked the process for logging and responding to complaints. The service had a complaints procedure clearly displayed in the communal areas of the home. This was also available in easy read and pictorial format. We viewed a sample of recent complaints. We saw from looking at these records that the complaint had been documented, responded to and analysed for future learning. Each complaint had a summary of the action taken to resolve the complaint, and there was a three monthly 'trend' analysis. This was to ensure any reoccurring complaints were investigated more in depth and in line with the registered providers complaints policy and procedure.

There was a full and varied programme of activities at the home. There were numerous photo albums which

were full of recent activities people had partook in. Some of these activities included, Zoo Club, live entertainment, pantomimes, Easter events and Dignity Action Day. In addition, we saw recent events which had taken place which included therapy dogs, laughter yoga, indoor gardening, and movie matinee. We saw there was an upcoming event planned to celebrate the 'Royal Wedding' which included afternoon tea and entertainment.

Good

Is the service well-led?

Our findings

There was a registered manager in post at Whittle Hall at the time of our inspection.

Staff and visiting relatives were positive about the registered manager. One staff member said, "You can notice the difference since [registered manager] has taken over."

Before our inspection, we had been informed that there had been some historical concerns with regards to the number of safeguarding and medication errors which had occurred at the home. The Local Authority had visited the home three times in last seven months and issued an action plan which the service was expected to work towards. We looked at the action plan as part of this inspection, and saw that the service had taken reasonable steps to address the shortfalls identified. We spoke to the Local Authority who informed us they were pleased with the progress the service had made and some further timescales had been agreed to allow for progress to be implemented.

The management team at the home were honest and transparent about past issues at the home. By them working closely with the local authority we saw this had a positive effect on the overall quality monitoring of the home.

We used the inspection as opportunity to discuss some lessons learned from recent safeguarding's and instances when the service felt it needed to improve its own practice. We were provided with examples of how each inspection at other sites and the working relationships with the local authority had strengthened the services own approach to quality assurance. We saw numerous audits and spot checks for different areas of service provision which were highlighted and actioned. For example one audit identified there was not enough 'service user voice' so people were invited to partake in 'you said we did' which included 'resident of the week meal choices.'

In addition to this, there were numerous audits which focused on different areas such as clinical care, falls reviews, dining experience, infection control and complaints. Each audit had robust action plans to accompany them if any areas of improvement were identified. For example, a health and safety audit identified that repairs needed to be completed one of the units. We saw this was assigned to appropriate person and actioned.

We spent time discussing quality assurance with director for quality and compliance. We viewed the quality assurance procedures and frameworks they had in place at the service as part of their oversight. This document was spilt into specific areas, which were mapped against CQC's domains for inspection. For example, the 'is it safe' section on the quality assurance document focused on checks such as medication training for staff, and the quality of risk assessments. The quality and compliance director completed these audits. This information then fed into the organisations own Key Performance Indicator (KPI) system, and any areas of concern or none compliance were flagged.

The culture of the home was friendly and hardworking. The management structure clearly wanted to

support staff to develop and this was evidenced through the additional training the service was offering to the staff.

Residents meetings took place were food was discussed as well as any other agenda items. We also saw surveys took place with visitors. Staff meeting items were analysed for themes and key issues.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

The registered manager was aware what was required to be reported to CQC by law. As this was the services first inspection there were no requirements for previous ratings to be displayed.