White Rock Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 January 2016 and was unannounced.

At the last inspection on 18 September 2013 we found the service complied with all of the regulations we inspected.

White Rock Nursing Home provides accommodation, personal care and nursing treatment for up to 30 older people, all of whom are living with dementia. There were 28 people using the service at the time of this inspection.

The service has 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.

We received mostly positive feedback about the service from people who lived there and their friends and relatives.

People felt safe living at the home. However, they were not always protected against the risks of potential abuse.

There were some aspects of medicines management and administration that needed improvement to keep people safe.

Staff were aware of legislation to support people's rights, however the documentation was under on-going review to ensure how people's consent to their care and treatment was sought.

Staff received a programme of training and development but some aspects of the programme were out of date and still to be delivered.

The home's environment had not been developed to take into account the needs of the people living with dementia. The provider was looking into how the environment could be made more user friendly for people living with dementia.

People's records did not always support the delivery of personalised care and people could not always be assured that they would therefore receive appropriate care.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received regular and on-going health checks and support to attend appointments. They were supported to eat and drink enough to meet their needs. The choices of food and drink available were not always clear or offered.

There was a positive atmosphere within the home and people received care and support from staff who had got to know them well. Staff understood people's individual needs and worked in a manner that respected people's privacy and protected their dignity.

We received mixed feedback about the activities available and how much people were able to participate. There was a programme in place and staff dedicated to provide activities.

People were confident they could raise concerns or complaints and that these would be dealt with.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

Aspects of the quality of service were monitored and plans were in place to bring these together into a specific quality assurance tool.

Staff felt they would be supported by the management to raise any issues or concerns.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People felt safe living at the home. However, they were not always protected against the risks of potential abuse.

Peoples' medicines were not always managed safely.

Staff had a good understanding of how to support people safely, however some aspects of documentation needed to be improved.

The service followed safe recruitment practices and there were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent before providing care but the supporting documentation was currently being reviewed to ensure consent to care and treatment was sought in line with current legislation and guidance.

There was a programme of staff training and development to support staff to gain relevant knowledge and skills although some of this training was yet to be delivered.

The environment was not ideally suited to meet the needs of people living with dementia.

People were supported to eat and drink enough to meet their needs. The choices of food and drink available were not always clear or offered.

People had access to healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

The atmosphere in the home was friendly and caring. People received care and support from staff who had got to know them well.

Staff we spoke with demonstrated their understanding of the needs of people who used the service and interacted positively with them.

People's privacy and dignity was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and treatment plans did not always support personalised care, so there was a risk that people might not receive appropriate care.

Staff were prompt to raise issues about people's health and wellbeing and people were referred to health professionals when needed.

People's concerns and complaints were encouraged, investigated and responded to in good time.

There was a programme of activities but we received mixed feedback about the range of activities that was available and how much people were able to participate.
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Is the service well-led?

Good

The service was well led.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

Aspects of the quality of service was monitored and plans were in place to bring these together into a specific quality assurance tool.

Staff felt they were supported by the management team.

White Rock Nursing Home Limited

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 20 and 21 January 2016 and was unannounced.

The inspection was carried out by an inspector accompanied by a specialist advisor and an expert by experience. The specialist advisor had experience and knowledge of best practice relating to the care of older people, particularly those living with dementia and end of life care needs. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked other information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with four of the people who used the service and ten visiting friends and relatives, to seek their views about the care and support being provided. We also spent time observing interactions between staff and people who used the service. We spoke with the provider, registered manager, deputy manager and eight of the nursing and care staff. We looked at the care and treatment records of ten people. We also reviewed records about how the service was managed, including risk assessments and quality audits, staff recruitment records, rotas and training records.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at the home. People's comments included "I feel safe here, the staff are very considerate"; "I feel safe here, there is always someone about"; and " feel safe in here, I press the mat on the side of my bed if I want help, they come to me quickly". Relatives were positive about the service. One told us "This is a very good home. My wife is very safe in here, there is always someone around".

Care staff we spoke with were clear about their responsibilities in relation to safeguarding procedures and were confident that the management would respond appropriately to any concerns they raised. However, there were some instances where safeguarding processes did not operate effectively. One person's daily records noted unexplained bruises on their arm. There was no record to say that this had been considered as a potential safeguarding issue. Another person's records showed that they could become aggressive during personal care. They had made allegations about an injury sustained and their records indicated bruises. There was no record of any investigations made and the managers told us they were not aware of the injury. The manager agreed to look at a safeguarding referral for this person.

For one person there was no recognition of possible restraint. A chart for the person instructed staff to hold the person's hands to protect the nurse who delivered care. We discussed with the registered manager that it was not clear in what way this was intended, or how staff should carry this out. There was no risk assessment or guidance for staff on this practice and staff did not recognise that this was a restrictive practice.

The failure to recognise and protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some aspects of medicines management and administration that we identified as needing improvement to keep people safe. Three tins of food/fluid thickener were left on an open tea trolley whilst the care worker took drinks to people. These can present a risk to people if accidentally swallowed and should be stored safely and treated in the same way as other prescribed medicines

Controlled medicines were stored appropriately However, these were not all being recorded in line with regulatory requirements. A nurse told us "I do not know where this is recorded but it should be." The registered manager told us they had been advised they did not have to record this particular medicine as a controlled drug but took immediate action to record them in the controlled drugs book which is good practice.

We found three tubes of medicine used for people who have a serious seizure. This medicine was kept 'just in case'. It had been stored for a number of years and was out of date. The nurse told us they had not been needed as people had not had seizures. There were also some medicines that were not named. A nurse disposed of these straight away.

The records of medicine administered were incomplete. We found five medicine administration records

(MAR) did not have a photograph to enable identification of the person. Dates of birth were not always recorded on the MAR and allergy information was not recorded. This was particularly important for one person whose care plan stated they were allergic to penicillin. Some MAR were not completed with signatures to show if medicines had been given.

Several people were prescribed a mild analgesic on an as required basis but did not have any guidance about what their individual signs were to know when they required this medicine. There were no pain assessments to support staff to know if a person's pain was improving or getting worse.

Topical creams and lotions were to be applied 'as directed'. However there were no specific directions for staff and there were no records for the staff to record when they applied products to people's skin. The daily records contained some entries but this was not consistent. This meant people may not have received the medicines they required for skin health and to prevent the development of certain conditions. We raised the medicine issues with the manager who agreed to take action to rectify them.

Medicines were stored safely and the temperature of the medicines fridge was monitored and recorded. Records were kept of medicines disposed of. A person told us "I get my medicine the same time every day. The nurse is very good she explains my tablets to me."

Care staff told us staffing levels were sufficient "if everything goes to plan". If a member of staff phoned in sick, regular staff would be asked if they could cover the shift before agency staff were requested. They said there was a good relationship between care and nursing staff and the nursing staff and managers would help out if needed.

There were rotas for all levels of staff. The registered manager told us that recruiting nurses had been an issue for the service. The service currently had eight permanent nurses and five bank nurses. The eight permanent nurses included the registered manager and the deputy. The provider and registered manager had been working with staff on shifts and a meeting was planned for all the nurses to promote team working. There had also been an issue recruiting domestic staff in the area, which sometimes resulted in care staff taking on domestic duties. The service had advertised for domestic staff and another member of staff to support the existing worker who led on activities.

The service followed safe recruitment practices. We looked at the recruitment records for two nurses and four care staff. Each file included application forms, health checks and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Checks were also undertaken to ensure nursing staff were correctly registered with the Nursing and Midwifery Council.

People's care plans contained risk assessments, including those for mobility, falls and pressure areas. However, for one person who was at risk of aspiration and their records contained an aspiration risk assessment but this did not include the signs of choking and/or aspiration. Although the guidance for staff was not in place for staff to follow in an emergency, the staff we spoke with were aware of what to do should an emergency occur. Staff were also aware of specific equipment used for assisting people with moving and repositioning. They told us they continually assessed people's needs as to the level of support required by each person could vary throughout the day.

The service had two staff designated as 'falls champions' who were setting up a new review process to improve on the existing one. There was an audit of the falls register and an action plan in place. However, the action plan had not been reviewed, for example, keeping an area of the service tidy and uncluttered and

clearing corridors. The registered manager and the deputy manager confirmed there was no update so far and the work was in progress.

People had a personal emergency evacuation plan that was reviewed each month. This included a summary of the individual's needs, to support staff and external agencies to continue to meet their needs in the event of an emergency.

The service was clean and free from any unpleasant odours. Staff confirmed they had training in infection prevention and control and described the procedures they had followed during a recent outbreak of infection at the service. Appropriate equipment was in place and used by staff.

Requires Improvement

Is the service effective?

Our findings

People were unclear about if they were asked for consent. One person told us "I don't tell them how I like to be cared for. They do knock on the door. I don't think they ask my consent". Another person told us "No, they never ask my permission for anything". A third person said "No, I can't choose when to get up and go to bed. They usually choose the right time for me". Relatives were also unsure about decision making. One relative said "I don't know about best interest decisions. I suppose the home has dealt with that". Another told us "The staff decide what she does".

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 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. MCA assessments had been completed by a nurse in relation to various aspects of one person's care plan. These included medical wellbeing, personal care, mobility and nutrition. There was also a list of suggested questions for use in conversations to assess their capacity in relation to specific sections of the care plan. However, for other people records were not clear about MCA assessments and who was able to consent to care for the person. The registered manager told us there was on-going work on specific MCA assessments.

Two nurses told us they had received training in MCA during the past year. They were clear about their knowledge and the rights of individuals to make their own decisions for as long as possible. Care staff told us they had received training relating to MCA and Deprivation of Liberty (DoLs). They understood and were able to describe clearly the basic principles of the MCA and how these applied to their role.

People can only be deprived of their liberty so that they can 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. Applications had been applied for but it was unclear if MCA assessments had been carried out prior to applications being made.

People had mixed views on the food. People's comments included "There is no choice of food, it just comes out. The drinks just arrive"; "I get enough to eat and drink, it is okay, there is no choice"; and "The food is lovely". Relatives told us the food was good and care was taken with one person to ensure they did not choke.

We saw people at one table had ordinary plates, knives and forks. This made eating difficult for some people. One person asked the staff member what the food was. They were informed that it was pork meatballs but were not given any assistance when they found it difficult to eat the meatballs. Another person was offered assistance but the staff member assisted by standing up and using a large spoon to put food in the person's mouth. The staff member sat down after the person had a few mouthfuls. People did not appear to be offered a choice of lunch or pudding. Staff told us there were alternatives available.

However pictorial menus and other prompts were not used to support people living with dementia to be aware they could request alternatives. We did observe people being asked about menu choices on the second day of the inspection.

We recommend that the registered manager researches and implements current best practice in relation to supporting people who are living with dementia to make choices about eating and drinking.

People's weight was monitored regularly and this identified people quickly when they required intervention because of weight loss. People were then referred to the GP and/or to a speech and language therapist (SALT). Records showed people had usually maintained or increased their weight. Care staff told us they were aware of those people at risk of not eating or drinking enough. They also told us if staff identified such a risk, senior staff took action and made sure the person's welfare and intake was monitored.

People had access to healthcare services and, where necessary, a range of community healthcare professionals were involved in assessing and monitoring their care and support to help ensure this was delivered effectively. The service used hospital avoidance plans for some people. Equipment was provided to support people's changing care needs such as alternating cell mattresses and bed rails. Relatives were consulted on these decisions. Where someone needed to attend hospital for an appointment or an emergency a transfer form and a copy of their medicine administration sheet was sent with them. The provider told us they always tried to send a care worker as well to ensure people had a familiar face to support and comfort them as well as help with communication where necessary. Staff responded to people who felt unwell and contacted the relevant GP appropriately.

The registered manager told us the service was a dementia specialist home. However, changes to the environment had not been made to follow best practice guidance. The toilet sign was high on one door and name signs of doors were not easy to read. The provider told us in their Provider Information Return in July 2015 that there were plans to purchase signage to assist people who were living with dementia.

People's rooms were not always arranged in the most suitable way. For example we noticed a person sleeping in bed with their head propped up and the sunlight directly in their face. The design of the service meant some people's bedroom windows opened into the dining area. Staff tried to mitigate this by closing windows and curtains, however it was sometimes necessary to have the windows open to prevent odours in people's rooms. This in turn could have an impact on other people's dining experience, particularly as the home was short of domestic staff and this meant people's rooms were sometimes not cleaned until later in the day.

We recommend the registered manager researches and implements best practice guidance for dementia friendly environments.

People told us they thought the staff were well trained and managed. However, the training record showed a number of staff were overdue updates in aspects of their training. Some training was planned and this included moving and positioning, fire safety, infection prevention and control and safeguarding people. The registered manager told us other training such as dementia awareness, person centred care and equality and diversity were also planned for the year. Nurses had recently attended training updates on tissue viability and further training on pressure area care was scheduled. Staff also had the opportunity to achieve qualifications in nationally recognised health and social care diplomas. Team leaders were qualified to level 3 and senior care workers held level 2 diplomas.

Staff told us they had an induction and worked alongside experienced senior staff when they started work.

They received essential training before they worked on shift and further training on an on-going basis. Staff confirmed they had supervision and appraisals and felt they were able to approach and seek support from the management.

Good

Is the service caring?

Our findings

People told us "The staff are kind and caring. I know all the staff and I am comfortable with them." Another person told us "The staff are very kind and gentle. They always knock on the door and tell me what they are going to do." Relatives felt their loved ones were looked after well. Comments included "I am very happy with the staff, they are caring and treat my wife well" and "I am very happy with how they treat my wife and others. I think they are very caring. They give personalised care and know all the residents. They phone me to review her care."

Staff showed respect when speaking with people while they provided support. Staff addressed people by their chosen names and demonstrated a good awareness of their individual personal preferences. For example, one person had several drinks in front of them. A member of staff approached them and asked if there was anything they would like to drink? Although the person said no, they offered to make them a cup of team "especially how you like it". The person accepted the drink and drank it straight away.

Relatives told us the service was homely and they received a warm welcome. They were able to visit at any time. One relative told us about an incident with their relative. The deputy manager had been unaware of the incident and immediately undertook to follow this up. They spoke with staff about record keeping and spoke with the relative to ensure they were alright.

Staff ensured people's privacy was protected by providing all aspects of personal care in people's own rooms. They told us they drew the curtains and closed windows when providing personal care to people whose windows faced onto the dining area. They also explained how they promoted people's dignity by keeping them covered during personal care and supporting them to do things for themselves.

When staff supported people to mobilise using the hoist, they did so carefully and respectfully. Staff reassured the person and explained what was happening at all times. They also offered blankets to keep the person covered if they felt cold. The people being supported appeared calm and relaxed.

Staff discreetly asked people if they needed to use the toilet and offered support where needed. Staff were clear that they did not undertake domestic tasks at the expense of the care team.

The staff were cheerful and the atmosphere in the home was relaxed. A member of staff with a lead role in activities spent time talking with a person about a nature programme on the television. The soundtrack featured natural sounds such as birdsong and a stream, helping to create a calm and relaxing atmosphere.

Requires Improvement

Is the service responsive?

Our findings

A relative told us staff were responsive to their relative's changing needs. They said "This service nursed her back to health after admission from another home"; and "From day one they have been fantastic."

The service used a mixture of records to record important information about people's needs and related assessments. Some of these records were not clear and there was often a disconnect between different parts of the care plan. The structure and information in the care plans did not support personalised care.

Care plans did not always contain clear guidance for staff in supporting people who became distressed, anxious or aggressive. One person's Personality and Behaviour Care Plan stated that the person could be anxious and agitated especially during personal care. Their care plan did not provide specific guidance to ensure the person received the care and support they needed. For other people, their daily records identified incidents where the person had become distressed or was resistive during personal care. There was no clear assessment, guidance or management plan in place to support people during these situations.

Daily records showed that personal care was delivered in line with people's care plans. Care plans contained information on mobility, falls and pressure areas as well as vision, hearing and oral health. The plans were subject to regular reviews and updates. The service had a system whereby nursing staff undertook care plan reviews on a six monthly basis or sooner if required. The deputy manager told us she had met with all the nurses and discussed care plan audits and mental capacity assessments. We saw an example of a care plan the deputy had audited, noted areas to be improved and given a copy of the notes to the designated nurse. However, people were not always clear about their involvement in the reviews.

The outcomes of the most recent six month review for one person had been compared with those of the previous review and this informed the person's ongoing care plan. For example, a moderate reduction in the person's appetite and weight had resulted in a risk management plan that was being reviewed on a monthly basis and included fortified food and additional snacks.

We received mixed views regarding activities. One person told us "I like to read, there is nothing else to do all day". Another person told us "I watch my TV all day, the staff do come and check on me". A relative told us "I don't know what she does all day, nothing I expect". Another relative told us "(A member of staff) does one to one with my wife. I don't know what she does with her".

There were two members of staff who organised various activities with people. These often had a monthly theme and photos were displayed in the hall. The activities included one to one sessions such as hand massages with people who were nursed in bed. One musician visited the home weekly and other musicians visited periodically to provide entertainment. We observed the activities co-ordinator spending time during the morning with a person, reading the paper together. A log was kept of a person's involvement in activities provided by the service. This was reviewed and alternative activities introduced due to health changes. Other activities the person enjoyed were continued.

The provider told us the care staff had a lot of interaction with people during the activities of daily living. Staff involved people and their families as much as possible in their care. A relative confirmed they were involved with a review. The provider also told us they maintained good communication with relatives and had an 'open door policy' for everyone.

People told us they knew how to complain. We were told "I have never complained. I would tell my daughter and then she could complain"; and "I have never had to complain, I would tell the staff." There was a complaints procedure in place and a log book showing the last recorded complaint had been in May 2014. The registered manager had investigated and discussed the complaint with the relevant people and recorded the outcome. The annual service questionnaire showed that none of those who had responded had found cause to complain.

Good

Is the service well-led?

Our findings

People told us they thought the service was well managed. One person told us "I think this place is well managed. I would recommend to my friends." Another person told us "I know who the manager is, she is very nice." Relatives and visitors had positive comments about the management of the service. One told us "The manager is very good, she helped us all settle in well." Another told us "I think this place is managed very well, we are all happy with it."

The registered manager, the deputy manager and the provider were all responsive to issues we raised with them during the inspection, acted on these quickly and were keen to improve the service. The registered manager told us they were meeting with staff on the final day of our inspection to discuss improvements in record keeping.

The management team worked closely together and had a good working relationship. They all had a good working knowledge of the people living in the service and were involved with external organisations and networks to help keep themselves up to date.

The registered manager sought feedback about the service from people, their relatives and staff. Feedback could be given via an annual survey or the provider's website. The current annual survey was underway and the results had not yet been collated. However, the results to date were overall positive.

Care staff told us the deputy manager and registered manager worked alongside them and "walk about and ask questions". They felt this approached helped the managers know what was going on in the service. Staff meetings were held and staff were able to contribute suggestions and know they would be acted upon. Staff felt they and the managers were all striving for the same goal and were "here for the patients". For example, a person's initial assessment on admission stated they were able to eat solid food. Staff identified this was not the case and a softer diet was needed. This led to a review and action taken.

There were clear lines of accountability within the service. Each registered nurse supervised a team leader, who was responsible for supervising a number of care staff. The registered manager oversaw appraisals of all staff, which included reviewing performance and objectives in relation to the previous appraisal. Staff told us the management were very approachable if any issues needed to be discussed outside of the formal supervision process.

The registered manager and deputy manager maintained a visible presence in the home and had regular discussions with the staff team about any improvements or changes that may be needed. Checks and audits were carried out on aspects of the service, such as care plans, a falls register, accidents and incidents, nutrition and hydration. The provider told us there were plans to introduce a specific quality assurance tool to formalise their current audits. The provider told us "White Rock is a small stand alone home and we believe that because of this we know the patients, staff and relatives very well".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse. Staff failed to recognise restrictive practice and to assess less restrictive options for support. Regulation 13(2) and (4).