Meridian Healthcare Limited

White Rose House

Inspection report

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Date of inspection visit: 7 July 2005
Date of publication: 29/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection of White Rose House took place on 7 July 2015 and was unannounced. We previously inspected the service on 23 June 2014 and found it to be non-compliant with regard to the care and welfare of people, safeguarding, cleanliness, staffing and assessing and monitoring the quality of service provision. The provider submitted an action plan to address these areas and this inspection checked whether improvements had been made. We found that the home had made some progress in these areas.

White Rose House care home provides nursing and personal care for up to 64 older people. On the day of inspection there were 55 people living in the home. The home is over three floors shared between nursing and personal care support.

People told us they felt safe living in White Rose House and we found that staff understood how to identify abuse and respond effectively to any concerns. Staffing levels

Summary of findings

were appropriate to the needs of the people in the service on the day of our inspection and we saw that medicines were administered, recorded and stored correctly in a locked room.

We saw that the service had comprehensive risk assessments but these were not always current and some were not written in a person-centred manner.

Staff had received an appropriate induction and subsequent regular supervision. Training was mostly up to date but we saw the service needed to offer further dementia awareness for staff.

The service was acting in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards legislation and people were consulted and referred on for further health support when needed.

We found that records relating to people at nutritional risk were not always kept up to date and in some cases, were inaccurate. This meant that people were not being consistently monitored and concerns identified. Mealtimes also evidenced limited choice for people as meals were ready-plated and condiments added without question.

Staff were caring when dealing directly with people and sought to obtain their consent re their care needs where necessary. However, we found not all staff were respectful when talking to each other about people living in the home.

The home had just appointed an activities co-ordinator and so were commencing a new programme of events and we found they were timely in their response to complaints. However, we found that not all records were written in a person-centred manner.

We found the home to have a friendly atmosphere and staff and people living there spoke highly of the registered manager and other senior staff.

The service had a registered manager 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.

We saw that audits of the quality of the service were limited and needed consideration such as analysis of falls and incidents. The registered manager provided us with a prompt action plan following our visit indicating areas they had actioned for improvement.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People told us they felt safe and staff displayed a sound understanding of how to recognise signs of abuse and what to do about it.

However, we saw that although all risk assessments were detailed in their content, not all were current or person-centred.

We found staffing levels to be appropriate to the needs of the service and that medicines were administered and recorded in a safe manner.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received a comprehensive induction. Supervision and training was not always effective as it did not consider the developmental needs of staff.

People's consent was sought for most elements of care but not always at mealtimes where we observed pre-plated food. People at nutritional risk were not always monitored in a consistent manner.

We found that people were referred to other health and social care professionals when needed, and that visiting professionals were complimentary about the home.

Is the service caring?

Requires improvement

The service was not always caring.

We saw positive relationships between staff and people living in the home and examples of sensitive and thoughtful care delivery but some staff interactions between each other suggested that some were more task focused in their approach to people's care.

People said staff were kind and friendly and we did observe this, particularly during the morning.

We observed that people's right to privacy was not always respected in terms of staff's discussion of confidential personal information. Staff were not always respectful of people when they talked amongst themselves.

Is the service responsive?

Requires improvement

The service was not always responsive.

We observed that there was little structured activity taking place in the home.

People's needs were not always met in a person-centred way as their basic needs had been missed and records also reinforced the view that the service was task-focused at times.

Summary of findings

Is the service well-led?

The service was not always well led.

People and staff felt the home was well managed and spoke highly of the registered manager and senior staff.

The registered manager was observed to be knowledgeable and approachable, providing clear direction and vision for the home. However, there was a lack of audits around the quality of service provision which meant records were not always accurate or up to date.

Requires improvement

White Rose 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.

The inspection took place on 7 July 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and one Expert by experience.

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 looked at information from the local authority commissioning team and notifications received with regard to safeguarding.

We spoke with 20 people living in the home and six of their relations or friends, six members of staff including a member of the domestic staff, two carers, a nurse, the activities co-ordinator and the registered manager. We also spoke with three visiting health professionals.

We looked at nine care records including medication records and three personnel files. We also reviewed quality audits including medication, care plans, maintenance records, accident and incident logs and risk assessments.

Requires improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the home. One person told us "It's lovely here. I feel safe here. It's a nice place. It's nice and clean". Another said "It's a good home to live in. I feel safe". A third person said "It could be worse. I feel safe. I don't feel threatened. I can't complain".

One relative we spoke with told us they "had never had any concerns around the staff. It is a good staff team". Another person living at the home said "My daughter knows that I'm safe here. Nobody's frightened here. I feel safe".

We spoke with two staff who told us they were confident to spot the signs of abuse and would take action to notify their managers and relevant agencies if they had concerns about a person's well-being. Staff said they understood whistleblowing and would report any bad practice without delay.

We saw the safeguarding policy and procedure and this had been recently reviewed. The whistleblowing policy or procedure was not in the documentation that we saw as it had been removed from the folder but the registered manager advised us there was one in place.

We asked them if they could give an example of a safeguarding concern and they gave a range of examples including not offering appropriate pressure care or making someone wait for a drink. They were not aware of any such incidents occurring in the home. This was later confirmed by the registered manager who advised us that they were aware of the process to follow.

We saw completed risk assessments for nutrition, moving and handling, pressure sore prevention, oral care and hydration. One person indicated they preferred to leave their bedroom door open and this had been properly risk assessed and signed by the person.

There were risk assessments in place for particular conditions such as in supporting someone with stoma care and managing percutaneous endoscopic gastrostomy, commonly known as PEG, feeds (where someone requires nutrition or fluid through a tube because they have swallowing difficulties). There was also additional information relating to particular conditions placed with the risk assessments to enable staff to develop better understanding of the issues involved and how this might impact on someone. It was evident that where high risks were identified other relevant health professionals were involved such as a dietician.

We did ask the registered manager about one for the prevention of burns and scalds which said that "hot drinks must be cooled down with plenty of milk (or cold water if the person does not like milky drinks". This was a standard statement on the care records which had been ticked but which denied the person choice of having a hot drink. We asked the registered manager about this and they said discretion would be used in each situation.

We looked at a sample of records for accidents and incidents that had occurred during the last four months. We saw these were recorded and there were comments on some of the forms as to how to avoid a repeat of such incidents. For example, where there were incidents of unseen falls, further comments showed 'staff to remind [person] to use nurse call'.

We saw there were monthly reports of accidents and incidents available for May and June 2015, but analysis of these was not robust. For example, one person had fallen four times in May and three times in June, yet they were not identified in the monthly reports. We looked at this person's care record and we saw their risk assessment of falls was rated as 'medium'. We also saw their moving and handling mobility assessment had not been updated since 15 May 2015, yet they had fallen six times since then. This meant that the service was not identifying specific issues which may have been resolved for individuals to reduce the amount of falls and lessen the risk of harm.

Risk assessments for individuals in their care records were not always accurate and we found conflicting information. For example, one person's record stated they walked with a stick, yet we had seen them walking with a wheeled tripod frame and there were no updates to show this had been reassessed or whether there was a change to the risk assessment.

One person had a risk assessment for falls that showed them to be high risk, yet there was little information for staff as to how to minimise the risk of further falls and the person had fallen five times in the month of April. This person's care record had been reviewed on 20/05/2015 and it stated 'full care plan reviewed. No identified changes', which did not account for the person having a significant

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Is the service safe?

number of falls. We spoke with the registered manager about our concerns and they agreed they would immediately review all care plans and re-assess risk in relation to falls. They showed this had been done on their submitted action plan dated 23 July 2015 and they had also sought advice from external healthcare professionals to ensure they had assessed correctly. This external team were happy with the work undertaken.

We spoke with one person who was in their room who told us "staff are always rushing around but all the staff are kind". Another person said "there's not always enough staff as I have to wait at mealtimes". A relative we spoke with told us they felt there were enough staff as "there was always someone around".

We asked staff their view of staffing levels. One member of staff said they were happy with the current provision but perhaps more cleaning staff would be helpful. This was later confirmed by a member of the domestic staff who said they felt they didn't always have enough time to do things thoroughly enough. We did not identify any concerns around the cleanliness of the environment.

Another member of staff said "It's OK at the moment although there have been issues in the past. There had been a lot of recruitment over the past four/five months and now we are fully staffed". They went on to tell us that all staff are asked to pick up shifts if someone calls in sick and they do cover for each other. They said there was a growing sense of teamwork among people working in the home. This was confirmed by the registered manager who advised us the last time an agency nurse was used was in March as their recent recruitment drive had been successful.

We saw during the morning there were sufficient staff supporting people and we did not see people had to wait. One member of staff said that "Each member of staff has a buzzer to identify where the needs are" and that all staff know to respond promptly. However, in contrast during the afternoon we saw lounge areas were unattended and people had to wait for staff to assist them. One person said they had 'been waiting a long time' for staff to bring them a cup of tea. We observed that staff tended to be completing records in the afternoon and were less visible to people in the home.

Staff we spoke with said they thought there was enough staff, although they said when people needed support at the same time it was not always possible to promptly attend to everyone. A visiting health professional said that it "was sometimes difficult to find people but that the senior staff were usually well informed". The staffing levels were appropriate to the needs of the individuals within the home.

We looked at medicine records. An information sheet outlined basic details including name, conditions and allergies. We saw that medicines were administered correctly and paperwork reflected this. It was recorded on the Medicine Administration Record (MAR) if a person had not had their medicines and why. Topical medication such as creams were recorded on a separate MAR sheet and completed by care staff. We saw that monitoring of the fridge and room temperatures was occurring daily. We checked that PRN (as required) medication and Controlled Drugs as defined under Misuse of Drugs Act 1971 were recorded and logged appropriately.

The home was decorated to a high standard and all rooms were clean and tidy apart from one where we found faeces splashed and smeared all over the toilet - inside the lid and down the sides, on wall, behind toilet and on the toilet brush. We raised this with a member of staff who said this was due to staff emptying the commode and that this matter would be dealt with promptly. The person in the room did not use the ensuite so was unaffected directly by this.

Staff handwash was available in all areas and staff were using personal protective equipment as appropriate. People told us "It's kept clean. I wouldn't change anything. I'm quite content" and "The cleaners are very good and the senior one is excellent. They change the flowers, they deserve a medal".

The environment included a restaurant and café for people to use as well as relatives. There was also a small library which provided a quiet area. Again, all there areas were well presented. We were told that one person asked for a green carpet for their room and one was purchased and a member of staff said that 'any new equipment could be ordered as needed'.

Requires improvement

Is the service effective?

Our findings

We asked people living in the home their view of the meals. One person told us "The food's alright. (For breakfast) you can have porridge or cornflakes. There are about four options. You get a nice taste of what you fancy". Another said "It's a nice cooked breakfast if you can eat it: full English, prunes and cereal". One person requiring a special diet said this was catered for and another who had suggested an alternative option of cauliflower cheese told us "they make it now". We saw that fresh fruit was also available.

However, other people told us "The food could be better. You get what they give you" and "Sometimes it's a bit boring. We live on peas and carrots. We could do with more fresh veg". This was the same for salad where it was "only ever lettuce, cucumber and tomato'", and fruit was only "apple, banana or orange". The lack of variety was also mentioned by another person although they said the food was "reasonable". A relative we spoke with said "The variety of the teatime food is not good. It's boring and it's not inspiring. The presentation is not great".

One person told that the "food is OK but lacks choice. There are only some days when I can say I have enjoyed my dinner or tea today". They told us that tea is served at 4.30pm which they felt was much too early and it always starts with a bowl of soup. However, they told us "we don't want soup on warm afternoons". We spoke with the registered manager about this who agreed to look into choice of food in more detail with people living in the home and to conduct regular audits in this area to ensure people's preferences were being catered for.

We spoke with one person who needed to have breakfast early to enable them to have their medication but this meant that they did not have the option of a cooked breakfast as day staff hadn't started by then. We asked staff why the medicines were needed so early and we were advised this was not the case and the issue would be looked at. The person expressed a wish to have "Alpen" muesli but was only given branflakes with raisins.

At 11.50am we saw people made their way to the dining rooms ('restaurants') and sat down to wait for lunch; however this was not served until 12.35pm and people became restless. We saw some people were not seated appropriately; for example, some sofa-style seating in one 'restaurant' was not supportive and caused people to sit casually and too far away from their meal. One person in a wheelchair was seated too low to reach their meal properly and this meant they struggled to eat with a good posture.

We saw staff were aware of what people had chosen for their meal and this was recorded on a list. People's meals were plated up and given to them with no consultation about portion size, who would like what, and for the meat option, gravy was poured for people without them being asked.

We spoke with staff who told us they understood people's dietary needs and their particular preferences.

We asked staff how people were assessed as being nutritionally at risk and were advised that people were weighed monthly and records were kept including any reasons for weight loss. However, we did find in one care record a contradiction between the daily log and the food intake chart. On the intake chart it stated that the person had had no snacks over a six day period despite being identified as losing weight and being weighed weekly. On two separate days minimal food was eaten, i.e. no breakfast, quarter of main meal, dessert and a sandwich for tea only. But on the daily record for each of these days it said "good food and fluid intake".

We asked a member of staff about how this was recorded and were told by one staff member that the information was recorded in a notebook they had on them. However, when we asked to see this the staff member did not have this and told us a colleague had told them. This example meant that the service was not accurately recording information that was important in ensuring the person received the right level of nutrition.

During the afternoon we asked to see food and fluid records and we saw these were not up to date. Some people's records had not been completed since the evening before and there was no accurate information recorded for those people who were at risk of malnutrition or dehydration. We spoke with one member of staff who told us: "I've done half, but I went for my lunch so I'm coming back to finish them off". We asked how staff could be sure what people had eaten if records were completed belatedly. Staff told us they could not accurately remember what people had eaten or had to drink. Where we saw fluid intake was recorded we saw these were always round amounts and at regular times, such as 10.30; 12.30; 14.30

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Is the service effective?

and 18.00. We questioned the accuracy of these records in terms of people's actual fluid intake with the registered manager. Following our inspection the registered manager has implemented a daily check with regard to completion of these and carried out further training with staff as to the necessity and purpose of these charts.

We saw on one person's care record an entry on 20/05/2015 that stated 'continue to monitor food intake' yet when we asked staff they told us they were unaware of the need to do this. We saw another person's care record showed they had lost 7.2kg in a two month period. The risk assessment showed the person at high risk of malnutrition. There was no information recorded on this person's care plan about any referral to their GP or a dietician and there was no clear indication about what was being done to protect this person's health, other than the record stated this person was on a food diary.

These examples demonstrate a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations as people were not being supported to ensure adequate food and hydration as records did not reflect this accurately, and therefore concerns in respect of nutrition and hydration were not being identified quickly enough.

We looked at staff files and found that staff had received a comprehensive induction. This was a detailed programme broken down into modules to be completed on a weekly basis and included topics such as the role of a carer, health and safety and risk assessments. Detailed booklets were completed by staff ensuring they had the opportunity to reflect on their learning and these were signed by both manager and employee.

Staff told us there were regular staff meetings and supervision, although staff seemed less clear about the purpose of supervision as a means of professional support. We saw in staff files evidence of pre-chosen topics such as safeguarding, fire procedure and infection control which reminded staff of the key areas of knowledge. However, there was no recording of individual progress or development discussions that we could see. Individual supervisions were regarded as meetings to discuss mainly areas of poor practice.

We spoke with two staff who told us they felt supported to undertake training on a regular basis so their skills and knowledge were up to date. This was evidenced in the training matrix which we looked at which indicated most staff had up to date training in fire, manual handling, safeguarding and medicines. However, dementia awareness training had not been received by all staff and the latest was in October 2013. This was of concern as some people in the home were living with a diagnosis of dementia.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff we spoke with told us they knew about mental capacity and how to support people to make decisions about their everyday lives. Staff said they had done some awareness training for DoLS and they knew some people lacked capacity to be able to leave the home unsupervised. The registered manager told us they had worked with the local authority to complete DoLS applications for people.

In the three care records we looked at we saw there was a two stage mental capacity test and a Deprivation of Liberty Safeguard assessment completed. Where best interest decisions were made these were documented. One person had a DoLS in place and we saw this was clearly documented with an expiry and review date

We found examples of mental capacity assessments which indicated when someone had capacity and also written consent by people living in the home to care planning and photographs in the care records.

One person told us "My health has improved no end since I came here". We found evidence of robust 'medical intervention records' which detailed what had happened in a particular instance, who had intervened and what the outcome was. There was also evidence of conversations recorded with professionals and family. Records were detailed in relation to pressure care with wound management being effective as we found evidence of pressures sores healing well. There was appropriate equipment available for people needing pressure relief.

We spoke with a visiting GP who told us they had no complaints or concerns about the way the home managed people's health needs. They said there was a good rapport between the GP services and the home and explained that

Requires improvement

Is the service effective?

issues could be raised with the registered manager at any time, who they were confident would act upon them. The GP told us the registered manager raised prompt alerts when they were concerned about a person's health.

We also spoke with two visiting nurses who said there was nearly always a member of staff to provide current knowledge about someone's condition. The visiting nurses complete a summary of their visit which is stored in the person's file. They had delivered some joint training to the staff on pressure care and fluid monitoring. This showed the home was responsive to people's health needs and sought advice and support where necessary.

Requires improvement

Is the service caring?

Our findings

We asked people how they found the staff and one person told us "The staff are very pleasant and they look after me well". Another said "The staff are very kind and very good but they don't stay. They do long hours, 12 hours a day. They are always short staffed". A further person said "The staff are quite pleasant, very nice".

People spoke mostly positive of interactions with the staff saying they were 'kind and friendly'. This was supported by relatives who said "The carers are fine" and "They do pretty well for her, she can't speak". One person told us that on the occasions that they have needed staff 'they have come very quickly'. This has included any medical attention or ambulance that was needed as well.

One relative told us there had been a marked improvement for their relative following a change in keyworker. Their relative had developed a good rapport with them and was now more amenable to receiving care support when required as the member of staff knew how to respond to them well. Staff told us they had keyworker responsibility for people and this role was to ensure people had everything they needed for each day.

We observed one member of staff talk to someone who had left their sticks in their room and was struggling mobilising safely. The staff member advised them to wait while they went to get their sticks for them which they did promptly.

We observed friendly banter between staff and people who lived in the home. One person hugged and kissed a member of staff and joked 'they should not wash their face for a week to keep the kiss on'. We saw staff were friendly and smiley with people and used a calm and quiet tone of voice in conversation.

In the morning we saw staff interaction with people was kind and patient. Staff spoke with people at face level, making good eye contact and offered a choice of drinks. People were greeted individually, mostly by name although on occasion staff used terms of endearment, such as 'sweetheart' and 'darling'. Staff took time to wait for people to make their choices.

We asked people living in the home if they were involved in decisions as to how they received their care and support. One relative told us their relative had been asked if they minded having a male carer as they were female prior to them starting. Staff told us that relatives were involved in the six month care plan reviews, or earlier if someone's needs had changed.

We saw people had signed their consent in files for their care delivery and we heard people involved in discussions about their care. One relative said they were waiting to review their family member's care with their family member and the registered manager.

We saw one person was struggling to walk as their trousers were loose. Staff noticed and discreetly assisted the person by adjusting their trousers. Staff offered assistance to people in a discreet way. For example, when staff asked people if they needed support to use the toilet they spoke quietly in the person's ear. We observed staff knocking and waiting for permission before entering someone's room.

However, we overheard one member of staff talking to their colleague "We'll get them all in for lunch, then do (person's name) after". The particular person was then spoken to with terms including 'sweet pea' and 'darling'. We did not feel this appropriate use of language for staff to be using. A bit later on we also heard "has she had any tea yet?" Even though this may have been a conversation between staff it does suggest that staff were not always respecting people as individuals, being more focused on the tasks that needed doing.

We heard the same member of staff say that someone had not had any tea because they were 'wandering'. This shows that the staff concerned had not been thoughtful in their choice of words to describe an individual's symptomatology who was living with a diagnosis of dementia

On one occasion we spoke with a member of staff and they used language that was not respectful or person centred when talking about the daily routine. For example, they said they would 'start chairing up' meaning people would be assisted to the dining room for tea.

We observed on two occasions people's catheter bags situated on the side of the bed and visible from the door. We asked staff about this and they were aware this compromised people's dignity.

We observed one person went to the salon to have their nails painted and staff played soothing music in this room. However, whilst this person had their nails painted we

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Is the service caring?

overheard the activities staff discussing another person's personal information with a member of care staff who was also in the salon completing care records. This was inappropriate and showed staff were not considering confidentiality guidelines

This was mirrored around the positioning of the nurses' station which was outside people's bedrooms. We overheard staff talking to GPs and taking phone calls about people living in the home.

These examples demonstrate a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations as staff did not demonstrate respect when to speaking about people with each other or protect people's privacy when discussing confidential personal information.

Requires improvement

Is the service responsive?

Our findings

We spoke with people about activities that were arranged in the home. “They have games and stuff which we can join in with, such as pass the balloon and we do exercise. We play dominoes, draughts and cards, all sorts of games and things” one person told us. Another said “I can go out in the garden when the weather is good”. A further person said “One day a week they bring a trolley round and you can buy things. They had a lady singer who came and they are setting up an indoor bowls alley”.

Other people highlighted the problem the home had had in securing an activities co-ordinator over the past few months. A relative also commented on this “In some ways they are quite lonely here. They forget things are on. Activities need to be advertised better than they are”. The home had had three co-ordinators since Christmas. However, one had recently been recruited and was just starting in their role. People were confident that things would improve as this person had been a carer previously so knew a lot of the people living in the home well. On the day of our inspection they were having a ‘pamper day’ doing manicures and hand massage. This provided some one-to one support for people able to access the relaxation room.

We saw staff invited people into planned activities. Staff told people about the spa day and invited them to join in. People were invited to have hand and foot massages and one person said they looked forward to that. People spoke about some of the planned activities and said they had enjoyed these. One person chatted about the previous day’s ‘family fortunes’ and said: “It was really good fun. [Member of staff] put some energy into it”.

We saw a member of staff sat in the lounge in the morning and chatted with people; they discussed what happened in the local community and what used to take place many years ago, such as bingo and singers in the local venues.

People mentioned “We would like to go out more. There was a trip out to the garden centre but they had to hoist us on to the bus. It was difficult and we didn't like it. It's the only one there's been in the five years that I've been here” and another person felt they could use the outside space more.

We saw that the home was designed with seating areas in and around the reception area and ends of corridors where space allowed. This provided some quiet space for people to read in addition to the specific library. People could access the garden and patio area directly from the lounge. We saw on the walls in the corridor areas there were photographs of the local area.

People told us they were supported at times to suit them. One person told us they requested a shower at 6pm and this happened on a regular basis. They told us “I get help when I need it”. Another person told us they liked to get up early and were supported by staff to have a hot drink at that time even though breakfast wasn’t served until 8.30am. We asked why breakfast wasn’t flexible but the person told us that more staff came on duty then and so this was when it happened. This was reiterated later in the day by someone who said they would prefer teatime to be later as they felt 4.30pm was too early. We could not establish why it was so early but did see it had been discussed at the residents’ meeting in May and the service was considering amending it according to people’s preferences. We spoke with the registered manager and they agreed to discuss this concern with people living in the home.

One person told us they had asked to move rooms as they did not like staring at the wall outside their room which faced their window. They said this was facilitated as soon as possible. Another told us they had their own phone which had been installed in their room.

One person showed us their room and explained they would like to use the shower. However, they were unable to do this because there was a big step up from the floor to access it. The person had requested a sit in bath but had been told the home were unable to meet this need.

One person said they already had a glass of water, but staff offered to bring them a fresh glass of water as the one they had had been poured a while. We saw staff offered appropriate help and support for people to have a drink. For example, one person needed their cup steadying and preferred to use a straw, so the member of staff sat patiently with them to make sure they could have a drink successfully.

We saw during the morning that staff were courteous with people and offered them choices, such as where they might like to sit. Three people chatted socially in the piano room,

Requires improvement

Is the service responsive?

they waited for a cup of tea and talked about the tennis at Wimbledon and what would be happening on the afternoon's television. These people told us they were happy living at White Rose House.

However, in the afternoon we spoke with one person who was very cross they had been moved in their wheelchair with no consultation. They told us: "I was sitting there, quite happy and someone just moved me over here, I didn't want to be moved and now I've got to get myself back again".

We looked at care records and found they were based on 'This is me' documentation which ensures that people are at the centre of care planning. There was a focus on the person's abilities in each record. We found some evidence of basic likes and dislikes were recorded. There were assessments of people's needs and preferences, and the level of support and intervention needed to assist them. However, not all were detailed spelling out how people wanted these needs to be met or who had been consulted in the completion of the documentation. We found that the records also contained details of advance care decisions where agreed.

We saw that care records were reviewed and any changes and actions as a result were signed by the person, where possible and a member of staff. It was also clear from the records who the person's keyworker was.

However, not all care records contained detailed information about people's social histories or backgrounds for staff to be able to engage in meaningful discussion or activities.

The recording in the care plans was not always person-centred. Statements such as "Hair to be washed regularly, brushed daily" and "Staff to carry out 3-4 hourly turns on [person]" suggested that the focus was on tasks. Another statement said "[person] is unable to participate in any leisure activities" which did not indicate the home were looking at every option to engage with the person despite their limited capacity.

In one person's file we saw a detailed care plan in place for a grade 4 pressure sore which had healed. There was no new care plan in place for prevention strategies. We pointed this out to the registered manager and this was amended immediately to reflect the need for ongoing pressure care. In another record it was stated the person could become agitated and staff were to support the person at these times, but there was no indication about how staff could offer meaningful support.

One person's care record stated staff were to check the person's hearing aid and glasses were available to them, yet we found the person had been without their hearing aid for some time and this was not recorded on their file. This showed that the home was not always focused on ensuring that person's needs were met appropriately.

We observed that many people were in bed throughout the day and we asked staff why this was the case. We were told that one person had severe dementia and another had contracted limbs and that it was felt they were safer in bed. However, when we asked how this decision had been reached it was evident that no assessment had been made for a more appropriate chair for people to sit in safely.

This is breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's needs were not always being met to ensure they could participate fully such as with the hearing aid loss, and the records did not reflect person-centred practice as they were focused on task completion.

One relative said to us "If I've ever had any queries they have been dealt with by the staff very quickly". We saw information about complaints and feedback was welcomed in the welcome booklet in the entrance. Feedback cards in the entrance invited people to make comments and we saw in the complaints record where people had raised issues these had been followed up.

We saw the complaints file contained information from when people had raised complaints or concerns with the home. We saw the home had recorded their responses in a timely manner to people's complaints.

The provider also recorded compliments. For example, a recent letter of satisfaction outlined a family were very happy after a staff member had accompanied their relative to hospital. The letter gave praise for consistency and quality of care and described 'kind, friendly and cheerful staff'.

Requires improvement

Is the service well-led?

Our findings

We asked people how they felt living at the home. One person told us "I'm happy here. I don't think anyone can grumble" and another said "It's wonderful here". Relatives also told us "We're quite satisfied with the home and we're happy with their care".

One person living in the home told us "We have a residents meeting every month and relatives can come in and air their views. At the meeting they ask us what we want to eat". We saw the minutes of the meeting held in May 2015 where action points were taken forward. They included discussion topics such as the support for the discussion group held every Friday and necessary improvements to the lift following people's concerns.

The minutes also showed the results of a recent customer satisfaction survey which had raised improvement points around activities, laundry and food. It was evident these had been actioned. We also saw the results of a customer satisfaction survey for 2014 which was displayed in the entrance and showed positive feedback about the service overall.

The atmosphere during the day of our inspection was friendly and people interacted well with each other. This was witnessed in the hairdressing salon where there were positive discussions. We saw staff communicated well with each other. For example, when going on breaks staff kept one another informed and when assisting a person they told a colleague where they were.

We asked people living in the home if they knew who the registered manager was. One person said "They are very approachable and so are the staff". Another person said "We do have very good management here" and named the three senior managers in the home. A relative said that "staff are always very supportive and I feel they are a good team". This relative said the registered manager was good at communication as this person did not live locally but was always kept informed of how their family member was, and from the discussions they had were confident that their relative's needs were well known and understood.

One member of staff told us they had been asked their opinion about how to retain qualified staff by the new provider. Another said they had suggested improvements to shift handovers which were being considered. This shows that the provider was keen to ensure staff's knowledge and experience was valued and utilised.

Staff we spoke with told us they thought the home was well run. One told us it was the relationship between the staff and people living in the home which was the 'draw' to working there. They said the registered manager knew people and would support staff if they needed them to, such as at busy times. We were given copies of the minutes of recent meetings for staff. These were categorised by job role and gave specific instructions as to how certain tasks should be carried out and whose responsibility it was for overseeing this. Staff were supported through these meetings to raise any concerns and to ask for further support if they felt they needed it. These minutes were written very clearly reinforcing the message that "we are here to meet the individual needs of clients, not fit the clients into our routine". The importance of team work was also stressed.

We asked the registered manager what they felt their key achievements were and they felt they had helped staff improve their understanding of their respective roles, and focused on trying to ensure activities were an integral part of the daily life of the home. They acknowledged the problems of trying to recruit to the post of activities co-ordinator but also accepted that all staff had a role to play in supporting people whether through conversation or assisting them into the garden. This was reflected in the staff meeting minutes. One of the nursing team was in the registered provider's award scheme regional finals for the 'nurse of the year' award.

The registered manager informed us of the challenges they faced which included implementing a new training system and ensuring all staff completed the new Care Certificate. They were also aware of the need to invest in further mental capacity and DoLS training for staff following the recent changes in legislation.

We looked at documentation that showed how the home was run. We saw there were regular audits in place for infection control and medication. We saw records to show there were many checks to premises and equipment that had been carried out in a timely way and were up to date. However, there was some information that we were unable to see to verify that equipment was in safe working order. For example, the service documentation for the lift stated

Requires improvement

Is the service well-led?

six-monthly checks, yet the last document was dated 27/10/2014. The inspection report for the hoists stated next check was due in June 2015; the manager confirmed the equipment had been checked but was unable to produce the documentation in support of this.

We saw an engineer's report in February 2014 that stated the fridge door gaskets were in poor condition. We saw another engineer's report in August 2014 that a warning notice had been given regarding the heating boiler and ventilation. We asked the registered manager about this and she confirmed the work had been carried out, but was unable to produce the documentation on the day of our visit. We were later sent these by the registered provider and found the checks had been completed as required.

We asked for an example of care plan audits and were shown the summary schedule of which ones had been reviewed. These had then been checked by a senior carer or the registered manager. We did not see the detail of what had been looked at and how any changes had been made. We asked how the registered manager ensured quality practice and they told us they conducted their own observations which were then fed back to staff (we did not see written evidence of this). This showed that the registered provider was keen to ensure high standards of practice but needed to evidence this more robustly so that it was clear where information had been shared and who had taken action to improve any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's needs were not always met in a person-centred way and this was reinforced by task-focused recordings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We heard conversations between staff which were not respectful about people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not having their fluid and food intake recorded accurately despite being identified as being at nutritional risk. There were also concerns re people not being offered choice in terms of portion size or condiments with their meal.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.