Farrington Care Homes Limited

Whitway House

Inspection report

Winterbourne Steepleton
Dorchester
Dorset
DT2 9LG

Tel: 01305889455
Website: www.farringtoncare.com

Date of inspection visit:
28 July 2016
01 August 2016

Date of publication:
22 November 2016

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**

Summary of findings

Overall summary

The inspection took place on the 28 July and 1 August 2016.

Whitway House is registered to provide accommodation and nursing care for up to 39 people in a rural area of West Dorset. At the time of our inspection there were 33 older people living in the home.

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

The home was last inspected in December 2015 and found to be in breach of regulations relating to: good governance and safe care and treatment including concerns about the safe administration of medicines. We told the provider to make improvements regarding the monitoring of the service people received by 7 March 2016. The provider told us they would make improvements regarding the safe care and treatment of people living in the home. At this inspection we found that the leadership of the home had not made adequate improvements and did not have sufficient systems to monitor the service people received and ensure that their care and treatment was safe. People remained at risk of harm because these improvements had not been made.

Audits had been undertaken but missed areas identified by inspectors. This meant health and safety issues had not been addressed and care plans were sometimes inaccurate or had omissions. Incidents and accidents were not always recorded and when they were their analysis did not always lead to people receiving safer care.

Staff used their knowledge of people to develop caring relationships with people. They also sometimes audibly discussed care tasks with reference to people in communal areas which did not promote dignity and respect. We have made a recommendation about promoting people's dignity and autonomy.

People felt safe but some people's risks were not reduced effectively because their care plans were not followed or records were not kept to review how these plans were working.

Staff understood the need to make decisions in people's best interests but decisions made did not always reflect the principles of the Mental Capacity Act 2005 (MCA). Opportunities for day to day choice making were missed.

People told us they saw health care professionals when necessary and were supported to maintain their health by staff. With the exception of evidence around care of people's skin, we found people's needs related to ongoing healthcare and health emergencies were met and recorded. People received their medicines as they were prescribed although the recording of creams was not consistent. We have made a

recommendation about the recording and monitoring of people's creams.

People were positive about the care they received from the home and told us the staff were kind. Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection. care was not, however, always delivered in ways that reflected people's assessed needs. We have made a recommendation about embedding person centred approaches to the care people receive.

People usually had support and care when they needed it from staff who had been safely recruited. These staff understood people's care needs and spoke confidently about the support people needed to meet those needs. They told us they felt supported in their roles and had undertaken training that provided them with the necessary knowledge and skills. There was a plan in place to ensure staff received the training they needed to stay up to date with the care needs of people living in the home.

People were at a reduced risk of harm because staff knew how to identify and respond to abuse. Information about how to report abuse was available to staff.

Deprivation of Liberty Safeguards (DoLS) had been applied for when people needed their liberty to be restricted for them to live safely in the home.

People described the food as good and there were systems in place to ensure people had enough to eat and drink. When people needed particular diets these were in place.

People were involved in a range of group and individual activities that reflected their personal preferences.

Staff, relatives and people spoke positively about the management and staff team as a whole and held Whitway House in high regard.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe because risks were not always assessed or responded to appropriately.

There were enough staff to meet people's needs but these staff were not always available where they were needed.

People received their medicines as prescribed but recording of creams was not consistent.

People felt safe and were supported by staff who understood their role in protecting people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always supported to make choices about their lives and decisions about people's care did not always clearly reflect the principles of the Mental Capacity Act 2005.

People told us the food was good and people's nutritional needs were understood and met by the kitchen staff.

Deprivation of Liberty Safeguards (DoLS) had been applied for when people needed their liberty to be restricted for them to live safely in the home.

People were cared for by staff who understood their needs, were trained to carry out their role and felt supported.

Most people had access to healthcare professionals when they needed them and staff followed guidance effectively.

Is the service caring?

Requires Improvement

The service was caring however people were not always treated with respect and opportunities to promote people's choices were missed.

People received compassionate and kind care from staff who knew about the people and things that mattered to them.

Is the service responsive?

Requires Improvement

People did not all receive care that was responsive to their individual needs and preferences.

People had access to a wide range of activities.

People and visitors had access to information about how to complain about the care at Whitway House.

Is the service well-led?

Requires Improvement

The service was not consistently well led and the required improvements had not been made.

People were at risk of harm because systems in place to monitor and improve quality were not sufficient.

The staff felt part of a strong team and told us they understood their responsibilities. However, we found evidence that they did not always share important information.

People and relatives held the home in high regard.

Whitway House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 July and 1 August 2016 and was unannounced. The inspection team was made up of two inspectors and a specialist advisor. The specialist advisor had clinical expertise in the care of people with dementia.

Before the inspection we reviewed information we held about the service. This included notifications the home had sent us and information received from other parties. The provider had not been asked to complete a Provider Information Record (PIR). 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. We were able to gather this information during our inspection.

During our inspection we observed care practices and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 11 people living in the home, three visitors, 12 members of staff, the registered manager. We also looked at 14 people's care records, and reviewed records relating to the running of the service. This included eight staff records, quality monitoring audits and training records. After the inspection we received emails from a further two regular visitors to the home who wanted to share their experiences.

We also spoke with two healthcare professionals and a social care professional who worked with the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in December 2015, we had concerns about how people were protected from the risk of harm because risks were not adequately managed including risks associated with medicines. Following the inspection the provider sent us an action plan and described how they would meet the requirements of the regulations. At this inspection we found that improvements had been made to the administration of medicines but people remained at risk of harm as risks were not appropriately assessed and managed.

People told us they felt safe. One person said: "I feel very safe. (Staff) help me. I feel safe in my room." Some people were not able to describe their experience with words as a result of their dementia or disabilities. These people smiled with staff and were confident when they interacted with them indicating they were relaxed in their company. Relatives were also confident of the safety of their loved ones. One relative told us: "It is safe. I can't fault the place."

Some people's risks were assessed and managed appropriately; however, we found that people were not consistently at a reduced risk of harm. This was because risks were not always adequately assessed and care plans related to risk assessments were not always followed. One person was assessed as being at high risk of choking and their care plan stated that they needed "direct observation" whilst they ate to reduce this risk. We observed them left unattended with their lunch and they started to choke. We highlighted this to a member of staff who attended to them. They did not record the incident or pass the information on to the nurse. This failure to follow the person's care plan resulted in a choking episode and the person was put at further risk as the information was not shared.

Risks associated with the environment were not sufficiently assessed. A person was described by a senior member of staff as being at risk of falling on stairs when they used them independently. We were told that a gate across the stairs was kept on a catch to ensure they did not attempt the stairs without staff support. Their care plan did not indicate this risk but the registered manger told us that the person had been encouraged to use the lift to reduce this risk. Other staff and the registered manager told us that the gate should be kept on a catch as it was part of a general historical response to the risk of people using the stairs unsupervised in an unsafe way. We found the gate was not on a catch frequently during our inspection. This put people at risk because staff were assuming that they would hear if anyone tried to use the stairs.

During our initial tour of the building we pointed out a large bottle of bleach left unattended in a communal bathroom. This put the people who moved independently around the home and had dementia at risk. Dangerous substances should be locked away to prevent people from coming to harm.

A steep angled and short homemade ramp had been built to enable people to use rooms that were a step up from the corridor. This ramp was made of wood and had no edges to reduce the risk of wheelchairs falling over the sides. The non-stick paper that had been put on the ramp was torn and missing. We asked if the use of this equipment had been risk assessed and the registered manager told us it had not. Most staff told us they felt comfortable using the ramp however for the safety of both people living in the home and the staff using the equipment its use should have been assessed for possible risks.

People who used wheelchairs were all assessed as needing lap belts on when they were outside of the home. We asked if anyone needed a lap belt whilst they were indoors. One member of staff told us that some people may need a lap belt inside as they may slip out of their chairs and that they could get a lap belt from the nurse. Another member of staff told us that lap belts were only used outside of the home. Care plans did not refer to the use of lap belts in the building. One person was being taken up and down the homemade ramp in their wheelchair daily. The use of this equipment by this person had not been risk assessed and the need for a lap belt had not been considered. We spoke with the registered manager who acknowledged that there were no personalised risk assessments about the use of lap belts within the building. People were at risk of falling from their wheelchairs because these risks had not been adequately assessed and staff did not have a common understanding of the risks people faced.

One person had two care plans related to how they would be evacuated in an emergency. The older care plan indicated that their mobility equipment would be kept in their room. The newer care plan indicated that their mobility equipment should be kept nearby. During our inspection the older care plan was being followed and their mobility equipment was kept in their bedroom. The person was at risk of being delayed if they needed to evacuate the building.

Two people had pressure sores that were being treated at the time of our inspection. We reviewed records related to the treatment of one person's care plan that was not improving. We found that there were regular gaps of one day in the records and one gap of up to five days with no recording about the person's pressure sore care. A nurse told us that they record this less because it is chronic and they would refer to the tissue viability nurse if there was a deterioration or there was no improvement. The person's sore was being reviewed weekly and no referral had been made to the tissue viability nurses since December 2014. We spoke with a tissue viability nurse who told us they would expect to be consulted where a wound was not improving and that a wound assessment should be carried out each time the wound is dressed. This can provide important information when a wound is chronic and not improving. We spoke with the registered manager who told us that following a recent safeguarding concern related to the care of a person's pressure sore specialist training in tissue viability had been sourced and this learning would be shared by those attending across the staff team. The person was at risk of receiving unsafe treatment because their wound was not adequately assessed and recording did not enable their care to be reviewed.

There was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff were confident they would notice indications of abuse and knew how to report any concerns they had. They knew who they should contact with any concerns. They told us they had received training on how to whistle blow and were confident to do so if needed. However, during a time when no staff were present in a lounge we observed an altercation between two people that resulted in one person hitting the other person. We informed a member of staff that this had happened and they informed the nurse that the two people had had "a set to". Later during the day, we highlighted to the registered manager and a nurse that no record had been made of this incident and the wellbeing of those involved had not been checked appropriately. The member of staff chatted briefly with both people when they were initially told but did not offer them the opportunity to move away from each other or check for injury.
Staff, people and relatives told us there were enough staff, usually deployed effectively to meet people's needs safely. They told us people did not regularly wait to receive care and staff were able to spend time talking with people as well as responding to their physical needs. We observed that this was the case most of the time although there were times when deployment of staff left people waiting for support or at risk of harm. For example, the registered manager told us that staff should be present in the communal lounge at all times when there were people in there, we observed that this was not always the case. Staff were

recruited in a way that reduced the risk of people being cared for by people who were not suitable to work with vulnerable adults. These checks had also been undertaken for agency staff working in the home.

Medicines were stored and administered safely with the exception of creams which were not recorded consistently. A senior member of staff told us that this recording was "hit and miss". They described difficulties with the recording system and explained that efforts were being made to ensure creams were recorded alongside people's other medicines. We saw that work was on going to ensure appropriate recording of all medicines and a particular emphasis had been placed on the use of as and when medicines. One person living in the home took medicine that was covered by the Misuse of Drugs Act. This meant the medicine required additional security to be in place. We checked and found them to be stored and accounted for appropriately. The recording of creams remained an area for improvement.

We recommend you seek advice from a reputable source about effective recording and monitoring to ensure people receive their creams as prescribed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that Whitway House was not meeting the requirements of the Mental Capacity Act (MCA) 2005 because best interest decisions had not been made in line with the legislation where people shared bedrooms.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The application of the MCA to support and underpin care delivery remained mixed. Staff understood that when people couldn't make decisions these were made in their best interests but records did not always reflect that these decisions were made following the principles of the MCA and staff did not refer to these principles in relation to their work. For example staff did not highlight the importance of promoting people's capacity to make decisions or considering their past and present views. We also looked at the records related to these decisions for the six people who shared rooms and did not have capacity to make this decision for themselves. Best interest decisions had been recorded for four of these people. The MCA outlines the factors that must be considered for a decision to be deemed in a person's best interests. The decision should be personal to the individual and include people's past and present views and their beliefs and values. It should also consider whether there are less restrictive options. The records reflected the way staff had described best interest decisions and did not address these principles. The decision had been made for all four people based on the fact that they enjoyed or appeared to enjoy the company of others. Relatives had been consulted but not asked about the person's previous views and beliefs. Less restrictive options had not been considered. Best interest decisions had not been recorded for the other two people who were sharing rooms. We asked the registered manager about this and they acknowledged they were not completed.

Mental capacity assessments and best interest decisions had been made and recorded for some decisions such as sitting up for meals, accessing healthcare, the use of lap belts when outside and the use of bedrails but this was not consistent for all the people who had been assessed as being unable to consent to their care. For example potentially restrictive decisions such as the decision to follow a care plan when the person cannot consent to their care; staff administering medicines and the use of the clip on the gate across the stairs had not been made within the framework of the MCA. One person who could not consent to their care had started to be cared for in bed and there was not an explanation for this in their care plan. We spoke with staff who were not sure why this decision had been made. They told us they thought the decision had been

made by the registered manager. We asked a senior nurse if this decision had involved input from other professionals with appropriate expertise about assisting people to move and safe seating options. They told us it would not have been useful to consult such professionals as the person could not contribute. The registered manager told us they felt the person was safer and more comfortable in bed. The person was at risk of receiving unnecessarily restrictive and socially isolating care and the decision to provide care in this manner had not been taken following the principles of the MCA.

People were at risk of receiving care and treatment that was not in their best interests.

There was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely and as such it is important that applications are made to protect people's human rights.

People and staff told us that the food was good. One person told us "Lunch was lovely." A relative commented that the staff are always able to spend as long as is necessary to support their loved one to eat. Another relative commented that their loved one had made necessary gains in weight since moving into the home. The chef and kitchen staff were committed to ensuring people ate meals that reflected their likes and their needs and had fostered a relationship with the Speech and Language Therapists to better understand people's needs. The menu offered a choice of dishes and alternatives were made available if people did not want these.

People's weights were measured regularly and there were systems in place to make sure that action would be taken if anyone became at risk of malnutrition.

People were supported to maintain their health and, with the exception of tissue viability specialist input, they saw medical professionals whenever this was appropriate. One person was having regular appointments related to a health condition and told us they were helped to attend these. Another person said: "I can see the doctor." Records indicated that changes to people's health were addressed quickly and input was sought in a timely manner. We spoke with a visiting health professional who told us they always received appropriate information and that staff followed their guidance.

People, and visitors, told us the staff had the skills they needed to do their jobs. One person said: "The staff are all very good." Staff told us they felt supported to do their jobs and told us how guidance from senior staff and their colleagues ensured they were kept up to date with people's needs. One member of staff told us: "I feel supported. I have a handover with matron." They described their training as appropriate for their role and that their professional development was reviewed through regular supervision. The supervision system included an opportunity for staff to feedback on the process. Staff told us they found this process supportive. There was a system in place for ensuring that staff training was kept up to date and training was reviewed in respect of the changing needs of the people living in the home.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people were not being treated with dignity and respect because their records were not being kept in a confidential manner. There was a breach of regulation. At this inspection we found improvements had been made and records were kept securely.

People's privacy was mostly respected: care was taken to ensure people's rooms were personalised and respected as their own private space and staff ensured that any support with mobility was done with dignity. A sign was placed on bedroom doors to ensure that no one entered whilst people were undertaking personal care and screens were placed around people whilst they were assisted with moving between chairs to wheelchairs. The placing of screens was not always well communicated or considered, for example we saw other people's view of the television blocked without explanation whilst a person was assisted to move into a chair. We also heard staff discuss care tasks and personal information audibly in communal areas. For example we heard a member of staff discuss a person's support in front of others in a communal lounge. We discussed this with the registered manager who told us they would address this practice immediately.

People were supported to make some choices throughout the day and care provided reflected this. People were encouraged to choose their food and drinks, what activities they joined and day to day decisions such as when they got up. Where people couldn't use words easily to tell staff what they wanted because of their dementia staff told us they took cues from people's demeanour and behaviour and then used the knowledge they had about the person to inform their support. For example a staff member described how they would see how someone reacted when they first went into their room in the morning and use this information to plan when they would support the person to get up. There were also missed opportunities for promoting choice and seeking people's preferences with specific respect to asking people where they wanted to spend their time.

We recommend you seek advice from a reputable source about considering the dignity and autonomy of people in ways that are meaningful to them.

People, and their relatives, told us the staff were kind and that they felt cared for. One person told us: "They (staff) are all lovely." Another person told us: "The staff are good people." A relative told us: "The staff are so caring…" We were also told by relatives that they felt their loved ones were respected because staff always took the time to speak with them. One relative described this: "They always stop and answer (them) and take the time to communicate and enable (them) to find the point of what they are saying."

Staff took time to build relationships with people in an individual way and spoke of, and with, people with affection. We saw lots of smiles from staff and people responded to these. Staff usually acknowledged people when they entered a room and took the time to make positive comments. They also spent time chatting with people before and during and care or support tasks. They spoke confidently about people's likes and dislikes and were aware of people's social histories and the relationships and activities that were important to them. We saw they used this information to encourage communication that was meaningful to people.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in December 2015 we found people were put at risk of harm because they were not receiving care that was responsive to their needs. There was a breach of regulation. The provider wrote to us and explained how they would meet the requirements of this regulation. At this inspection we found improvements had been made regarding the reporting of care provided however improvements remained necessary to ensure the care people received was appropriate to their needs and reflected their preferences.

People told us that they felt cared for. One person told us: "I do like it here. They look after me." Staff reviewed and discussed people's current care needs at handover and this ensured that people experienced continuity of care. People's care needs were assessed and these were recorded alongside plans to meet these needs. Records showed that these needs were usually reviewed monthly and care plans were updated to reflect changes. For example one person's care plan had been updated to reflect changes in the support they needed with food following input from a Speech and Language Therapist.

Care plans did not always reflect the experience of people. One person's care plan indicated that they should listen to radio two and this was reinforced by a sign on the radio in their bedroom highlighting this to staff. The radio was not tuned to radio two during our inspection. We pointed this out to staff who changed the setting immediately. The person was not receiving care that reflected their preferences. Another person needed one to one support to eat and they had to be left on five occasions during their meal because the staff member had to go and support other people.

People did not always receive support that was responsive to their needs and preferences. For example over a lunch time some people were not asked where they wanted to eat and remained seated in the chairs they had spent the morning sitting in. One person waited ten minutes longer than the other people sat in the lounge before their food came. This did not reflect a person centred approach to mealtime support.

Throughout our inspection most people who sat in communal areas remained in the same chair, only moving when they were supported with personal care. These chairs were not laid out in a way that promoted social interaction and people were not asked if they wanted to move.

We recommend you seek guidance from a reputable source about how to embed person centred approaches to the care and support people receive.

Records indicated that relatives were kept informed and their knowledge about their relative was valued. Relatives also told us that this was the case explaining that they always felt they were informed and consulted appropriately.

Activities were planned for groups and individuals by an activities coordinator. People told us that the activities were varied and appreciated. During our inspection some people spent time engaged in their own choice of activity in their rooms. Other people took part in organised activities and individual trips out with a

member of staff. We spoke to the activities coordinator who explained that they were part of a network of activity coordinators and this supported them to develop the activities available to people. They had been to one meeting and planned to go to more. There was a wide range of activities available regularly to people including trips out, baking and craft work. The home had adopted a donkey and the donkey visited the home twice a year which we were told was a big success with most people. Activities were also linked to events such as Wimbledon and the chef and kitchen staff supported these with event specific food. People who were cared for in their rooms had access to the activities coordinator for individual activities such as hand massage. One person had an interest in gardening and beds had been built for them and they were teaching the activities coordinator how to garden. This showed respect for the person's preferences and skills.

Most relatives told us they would be comfortable raising concerns and complaints. One relative told us "I don't have any complaints but I could talk to anyone if I did." Another relative told us: "The manager is approachable." No complaints had been recorded since our last inspection. There was information available to people and visitors about how to make complaints which included external agencies that could be contacted.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 we found that there were insufficient systems and processes in place to monitor the quality of the service. There was a breach of regulation. We took action and told the provider to make improvements by 7 March 2016. At this inspection we found that whilst some improvements had been made, the systems remained insufficient to ensure the quality and safety of the service people received. There was also a failure to adequately address other areas of concern identified at our last inspection. For example the importance of the legislative framework provided by the MCA was highlighted at our last inspection. The failure to address these identified concerns indicated significant shortfalls in the way the service was being led.

Systems were in place to ensure that care records were reviewed and care plans updated. We saw that these audits identified some documentation that was missing and that this had been put in place in people's files. For example an audit had identified that best interests decisions where needed for some people around the use of bedrails. These decisions had been made and recorded. The audit had not, however, picked up that best interest decisions had not been made regarding people's use of shared rooms when they did not have capacity to make this decision. We saw that four people whose care plans were not accurate or had information missing during our inspection had been audited and found to be 100% accurate. The system for auditing was not effective in picking up inaccuracies and omissions in people's care plans and left people at risk of receiving inappropriate or unsafe care.

Following our last inspection a risk audit had been undertaken to review health and safety in the home. This was commissioned by the provider and approved by the registered manager. The use of stairs and the use of wheelchairs were assessed as part of this audit. No risks were identified about the use of gates to protect people from falling on the stairs. The audit also incorrectly stated that all people who regularly used a wheelchair had been assessed by a physiotherapist and that the risk of people falling from chairs had been assessed. This meant that health and safety concerns identified during our inspection had not been identified or addressed as a result of this audit and people had remained at risk.

Accidents and Incidents were not always recorded by staff and this meant that people's care could not be reviewed effectively. During our inspection we saw two incidents which put people at risk of harm that were not recorded. Where records were made the registered manager reviewed and analysed the information. This did not always lead to the person involved receiving a safer service. One person had fallen on a number of occasions. An analysis of these falls had identified a time period when they were more at risk. This had not led to a change in the person's care plan to highlight this with staff. We asked two staff about the person's risk of falls and they did not identify that their falls risk may be higher at the time identified in the analysis. This meant the risk identified by the quality assurance process had not been communicated to staff and as a result had not led to staff being more vigilant at the time of day when the person was at increased risk of falling.

There was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whitway House was held in high esteem by the people living there, relatives, and staff. Most people told us they thought the home was "lovely" and made comments like "there is nothing I would criticise." And: "There is a lovely feeling… calm, welcoming and lots of laughter. I think this is an amazing place." Staff told us they enjoyed working in the home. They described being part of a strong team, including the regular agency staff, that worked well together. One member of staff said "We get to know everyone as a family. There is good teamwork." They told us they felt able to share their concerns and ideas with the management team who they described as approachable. One member of staff commented: "I can always talk to Matron (registered manager)." They also told us they understood their responsibilities. This was not supported by the evidence we gathered regarding restricted choice making opportunities and the recording and response to witnessed incidents.

The registered manager told us that they keep up to date by liaising with other healthcare professionals and described how staff involvement in a project around diabetes had updated and improved knowledge. They also told us that the provider visits regularly and is available by phone for support and advice. Professionals working with the home reflected good communication with the nurses and registered manager but some also acknowledged that some practice could be updated and recording improved.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care was not being provided following the principles of the MCA. Best interest decisions had not been made for potentially restrictive care practices. People were at risk of receiving care that was overly restrictive and not in their best interests.

The enforcement action we took:

Notice of Proposal with positive condition to report.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not receiving safe care and treatment because risks to their health and safety were not adequately assessed. People were not protected by care that did all that was reasonably practicable to mitigate risks. Equipment used had not been appropriately risk assessed.

The enforcement action we took:

Notice of Proposal with a positive condition to report.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service people received. Records were not made of incidents where people were at risk of harm.

The enforcement action we took:

Notice of proposal with a positive condition to report.