Whiteladies Residential Home Limited

Whiteladies Residential Home

Inspection report

22 Redland Park
Redland
Bristol
BS6 6SD

Tel: 01179739083

Date of inspection visit:
28 June 2017
29 June 2017

Date of publication:
24 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 28 and 29 June 2017. The inspection was unannounced. Whiteladies Residential Home provides accommodation for up to 25 people who need personal care. At the time of our inspection there were 21 people living in the home.

There was a registered manager in place 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.

People were not safe. Risk assessments and risk management plans did not identify and mitigate risks to people's safety. These included risks associated with the unsafe use of equipment and risk due to lack of operational systems to check the safety of fire, water and electrical provision. People's medicines were not safely managed. People did not receive their medicines safely and people's medicines were not stored safely.

Quality monitoring systems were not in place to identify, monitor, manage and mitigate risks to people's safety and welfare.

Staff that had received training with regard to safeguarding people from harm and abuse. However, they had not always fulfilled their responsibilities and people's concerns were not always recorded or reported.

Consent to care was not always sought in line with legal requirements and there was insufficient detail of best interest decisions made on behalf of people.

We have made a recommendation for the provider to review the staffing levels in the home. We also made a recommendation for the provider to introduce a nationally recognised tool to identify people at risk of malnutrition.

Staff had access to, and obtained support and guidance from, external health care professionals.

Staff demonstrated a kind and caring approach when they were supporting people who used the service. When staff spoke with each other, they did not always refer to people in a respectful or dignified way. Staff knew people well. However, people's likes, dislikes, choices and preferences were not always recorded.

There were activities that people could participate in and people were enjoying group activities on the days of our visit.

People and relatives told us the registered manager was readily accessible and available to them. Staff told us they were well-supported and described the home as a good place to work.

Following this comprehensive inspection, the overall rating for this provider is 'Inadequate'. This means it has been placed in 'special measures'. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Full information about CQC's regulatory response to these concerns will be added to reports after any representations and appeals have been concluded.

During this visit, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not safely managed. Risks to people's health and safety were not managed and safe care was not always delivered. The premises were not safely maintained.

Staff had been trained in safeguarding people from abuse. However, staff did not always recognise and respond appropriately to allegations of abuse.
There were concerns that sufficient staff was not provided at night and that peoples' care needs may not be met, especially in the event of an emergency.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not meeting the requirements of the Mental Capacity Act 2005. Best interest decision making was not always undertaken in line with legal requirements.

People had access to healthcare professionals.

Staff received mandatory training to carry out their roles. Staff did not receive sufficient training to provide support for people with mental health needs.

Staff felt supported. However, their performance was not always monitored on a regular basis.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us staff were kind, caring and respectful and we saw people being treated with kindness and compassion.

Staff did not always speak about people who used the service in a respectful way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were not always involved in planning and reviewing their care plans.

The records relating to people's personal care requirements were task focused and not personalised to people's individual care and support needs.

People had opportunities to participate in social activities and events.

A complaints procedure was in place. Relatives told us they were confident that issues raised would be addressed.

Is the service well-led?

Inadequate

The service was not well- led.

There were insufficient systems in place to identify or mitigate the significant risks to peoples' safety.

Sufficient systems were not in place for the monitoring of quality and safety. The audits that had been completed had not identified the shortfalls we found. Some audits provided inaccurate information.

People and staff spoke positively about the registered manager, and told us the home was well-managed. People had the opportunity to provide feedback and this was acted upon.

Whiteladies Residential Home

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 was 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.

We undertook a comprehensive inspection of Whiteladies on 28 and 29 June 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors on 28 June 2017 and one inspector on 29 June 2017.

Before carrying out the inspection we reviewed the information we held about the home. We reviewed the 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 the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with eleven people who lived at the home, three relatives and a visiting entertainer.

We observed the way staff interacted and engaged with people. We spoke with the registered person, and eight staff including care staff, catering, activities and housekeeping staff. We observed how equipment, such as call bells, pressure relieving equipment and bed rails were used in the home. We observed medicines being given to people.

We looked at six peoples' care records. We looked at medicine records, staff recruitment files, staff training records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, the registered person sent us further information that we had requested.

Inadequate

Is the service safe?

Our findings

People were not safely cared for. Risk assessments were not always completed and where risks had been identified there was insufficient guidance for staff to follow to mitigate the risks identified.

For example, one person had been assessed as at high risk of falls. The guidance for staff was 'High risk of falls. No longer walks but at times will try to get out of chair. Staff need to be aware of this and to check her at all times'. When we checked the person, they did not have a call bell to hand. We were later told by a member of staff the person was unable to use the call bell. There were no records to confirm the frequency of checks staff undertook to keep the person safe.

Bed rails were not always used safely. Protective bumpers were not being used. We spoke with the registered manager who told us the bed rails had been supplied by external health professionals. They told us they did not realise they needed to complete risk assessments to make sure the equipment was safe. There was a risk of the person becoming entrapped between the rails. The registered manager told us they would arrange for bumpers to be fitted.

One person had a pressure ulcer risk assessment completed in August 2015. It was recorded at that time that the person was "a high risk of pressure sores". The records stated the staff were to 'check all pressure areas and [apply] cream every day'. The person had been provided with a pressure relieving mattress for their bed and a pressure cushion for their chair. There were no records to guide staff about how often the person needed support to change their position. We visited the person in their room during the first morning of our visit and checked again later in the day. The person sat in their chair all day without the pressure cushion being in place. There was no information in the care records to confirm their position had been changed. This meant the person was at significant risk of their skin condition deteriorating.

The environment was not maintained to ensure it was safe. The sash windows in corridors and bedrooms did not have window restrictors fitted. The registered manager told us they thought restrictors had been fitted at one time, but may have been removed when the windows were painted. The Health and Safety Executive provides specific guidance about health and safety in care homes. This guidance includes actions to take because of the risks of people living in care homes, staff and visitors, falling from height. The guidance had not been followed.

We checked the water temperatures and found there were no controls in place to limit the temperatures of the hot water and eliminate the risks of people being scalded. There was one bath for communal use and six baths in people's bedrooms. There was one shower for communal use and four showers in people's bedrooms. The registered manager told us no one in the home used the baths. They told us everyone preferred showers. They told us that staff recorded the water temperatures of the showers before people used them. They were unable to locate the records for these checks and later told us staff had not been completing them. The Health and Safety Executive provides specific guidance about managing the risk from hot water in care homes. This guidance had not been followed. This meant people were at risk of being scalded with hot water.

The registered manager contacted us after our visit and told us they had taken action to restrict the window openings and interim measures had been taken to reduce the risks of people being scalded. They told us further actions were planned.

The local fire and rescue service completed an inspection of Whiteladies on 1 December 2016. They wrote to the registered manager following their visit, to request an action plan to address the significant findings of the inspecting officer. The registered manager sent an action plan to the inspecting officer and confirmed that all works were being completed by January 2017. However, one of the actions signed as completed on 3 January 2017 was that a five year electrical fixed installation certificate had been obtained. The registered manager was not able to show us the certificate during our visit. We asked for it to be sent to us after our visit and we received part of it. We asked for further information to be sent to confirm if there were actions required, and to confirm the date of issue of the certificate. We did not receive this information.

Fire risk assessments and risk management plans were not sufficient and did not protect people and staff from harm. Three people smoked in their bedrooms. For one person, the guidance for staff in the person's care plan was, '[Name of person] does smoke. Care staff need to be aware of this and make sure that at night the patio door is closed and locked'. When we discussed this person's care and safety with a member of staff, they told us the person had a fire retardant blanket and an ash tray, and that the person had been told not to smoke in bed. However, this was not recorded. In addition, in another bedroom where the person smoked, there were multiple cigarette burns on the person's carpet. We brought our concerns about the health, safety and welfare of this person, the other two people who smoked, other people living in the home and staff working in the home to the attention of the registered manager.

Since the inspection the registered manager confirmed they have completed risk assessments for people who smoke in their bedrooms. The registered manager sent us a copy of the completed risk assessment for one person.

We were told by the registered manager that a legionella check had been completed by a contractor in June 2017 and the report had not yet been received. We checked again with the registered manager on 13 July 2017 who told us they had been unable to obtain a report. They told us the provider was arranging for another contractor to complete a legionella assessment. The Health and Safety Executive provides specific guidance for care homes about legionella. This includes regular checks that should be carried out within the home, by the provider, on a regular basis. We noted that the regular recommended checks to reduce the risks associated with legionella had not been completed. For example, the checks on water outlets not in use had not been checked. This meant people were not fully protected from the risks of legionnaires' disease, a potentially fatal form of pneumonia.

Medicines were not safely stored, recorded or administered. The amounts of most medicines received into the home were printed onto the medicine administration records (MARs). However, the amounts were not always checked and signed by staff to make sure the amounts were correctly stated. Where medicines were left over from previous months, these amounts were not recorded. Some MARs had prescribing instructions handwritten by staff with the name and dosage of medicine required. The entries were not always signed or dated by staff. This meant accurate checks of stock levels of medicines could not always be completed.

Medicines were stored in locked cabinets and cupboards and on a shelf in a designated medicines storage room. The temperature in the medicines room was taken and recorded each day. We checked the temperatures that had been recorded and found 21 days in May 2017 and 20 days in June 2017 where the temperatures had exceeded the 25 degrees centigrade recommended. Medicines were not being stored at suitable temperatures, as recommended by manufacturers. A small refrigerator that was not lockable was

kept in the medicines room. This was not currently being used and was not plugged in. We were told that at the present time, no medicines required cool storage. The provider's policy stated, 'A lockable fridge is provided.'

We found a plain brown bottle in the medicines room with a hand written label that stated 'Paracetamol'. This was the only wording on the bottle. We were told by a member of staff that this medicine was for staff use. There were no records to confirm if or when these tablets had been given to staff.

We observed medicines being given to people. The medicines were not given or recorded safely. The member of staff did not dispense medicines directly to people from their original containers. They had taken each person's medicine that was due to be given that morning from its container and dispensed them into 'medicine pots.' They wrote the person's name onto a piece of paper which they put into the pot. They carried all of the medicines due to be given in the morning in the containers which were placed in a large plastic container. In addition, they had signed the MARs to confirm people had taken their medicines, before they had actually been given.

Some people were prescribed pain relieving patches. These patches are applied, usually every seven days, to the skin. There are manufacturer's instructions about suitable areas on the body where patches can be applied. The manufacturer's instructions also state not to reapply a patch to the same area of skin, for a period of approximately three to four weeks. We spoke with the member of staff who administered the medicines. They told us there was no system in place to record where the patches had been previously applied. This medicine was not being used in accordance with manufacturer's instructions.

The following day medicines were administered directly from the medicines trolley. However, we still observed the member of staff signing one MAR before they had given the person their medicines. We also observed the medicines trolley was left open and unattended by staff for three minutes while the staff went into a person's room. We saw that on 27 July, the day before our visit, there were gaps on several peoples' MARs. The records had not been signed to confirm the medicines had been administered as prescribed. We checked the blister packs and saw the medicines were not still in the packs. We spoke with a senior member of staff who told us they would follow up with the staff that had administered medicines on that day.

One person asked the member of staff to leave their medicines in their room. The member of staff told us, "We leave [the medicines] and she takes them when she's ready". This meant the person, who had not been assessed as safe to self-administer their own medicines, may not have taken them as they were prescribed. The medicines had been left unsecured on the top of a set of drawers in the person's room.

Some people were prescribed medicines to be taken when needed, for example, for pain relief. People were not always asked if they needed these medicines. The care records did not provide detail about the circumstances in which these medicines were required. The records did not describe the types of pain and did not explain what signs each person may show if they were in pain. This meant people may not receive medicines when they needed them.

One person was prescribed and was being given their medicines covertly. This meant the person did not know they were being given. The member of staff did not try to give the person their medicines overtly in the first instance. The provider's policy for covert medicines stated, 'All cases must be discussed fully with the pharmacist prior to administration.' The records did not confirm that the pharmacist had been consulted.

Some people were prescribed creams and ointments that were kept in their bedrooms. We found creams that did not contain the prescriber's instructions. We also found creams that had the name of the person for

who it had been prescribed scribbled out in pen.

Where people were prescribed variable doses of medicines, the amounts actually given were not always recorded. Where people were prescribed medicines for pain relief or for anxiety, the care records did not provide detail about the effectiveness of the medicines.

A disposals and returns book was used to return medicines that were no longer required. The pharmacy supplied most medicines in blister packs. A member of staff told us if people declined or did not need their medicines, and they had already been taken out of the blister pack, they returned the medicines to the blister pack and taped over the back of the pack to stop the medicine falling out. This meant people were at risk of receiving medicines that were contaminated because they had been handled or medicines that were not prescribed for them.

We reported our concerns about the unacceptable and unsafe practices to the registered manager.

The registered manager told us that since the last inspection there were a greater number of people living in the home who had mental health conditions and needs. One member of staff described the behaviour of one person as, "[Name of person] has a funny five minutes every now and again." They did not demonstrate an understanding of the support the person may require due to their mental health condition. Another person had been prescribed medicine to relieve anxiety. The care plan did not provide guidance for staff about how to provide safe care and support. Staff were unable to explain or describe how they were able to meet the needs of people with mental health needs.

Some areas of the home were not clean. For example, linoleum in bathrooms was torn in places, the bath hoist was dirty and the seat was covered with hairs. Many items of furniture in the communal areas were worn and stained. The stair carpet was worn in areas. The registered manager told us redecoration was planned and new furniture was being purchased in 2017.

Infection control practices were not in line with up to date Department of Health guidance. The guidance was not available in the home. We saw that staff wore gloves inappropriately. We saw staff wearing the same gloves as they went in and out of different peoples' bedrooms. We also saw medicines being given to people by a member of staff who wore one glove. For some people they used their gloved hand to take the medicines from the container and place the tablets into peoples' mouths. They used the same glove for each person.

The above all amounted to multiple breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people who used the service and from staff with regard to staffing levels. One person told us, "It's difficult to say if there is enough staff. I've only rung the bell once or twice." Another person commented, "Well, you know sometimes we have to wait but it's usually not too long." A member of staff told us, "Staffing levels are ok. It's got better." There was one member of staff on waking duty at night in the home. The records did not provide confirmation about the actual checks staff completed at night, or the specific care and support people received. The call bell system was not auditable, so there was no way to check when people had called for assistance. The registered manager did not use a dependency tool to assist in decision making about the staffing levels required. The home was spread over four floors. Peoples' bedrooms were on three of the floors. Three people in the home who were unable to use their call bells needed the support of two staff for personal care. However, only one member of staff was available from ten pm to seven am. A second member of staff was on sleeping duty in a separate building just behind the care

home. This meant there was a risk that people may not receive care when they needed it, or in the event of an emergency.

We recommend the provider reviews staffing levels using a recognised dependency tool.

We spoke with people who told us they felt safe in the home. Comments included, "I feel perfectly safe" and "I've always felt safe here." However, we found risks to people's safety were not sufficiently assessed and not sufficiently managed. Safe care was not delivered.

Accidents and incidents were reported and recorded by staff. We looked at recently completed accident reports and found there was a lack of detail. For example, "Found [person's name] on the floor – no injuries noted". There was no recording to describe how the person had got up off the floor, or how often staff had checked them afterwards. The majority of accident reports had been reviewed by the registered manager. There was limited detail in the reviews and these had not been dated. One review recommended, 'Care staff to keep checking her as she is unable to use the bell.' There were no further records to confirm how often the person was checked. For another person it was recorded 'Has been asked to ring the bell when she wishes to move'. There were no records to show that falls had been analysed or that people had been referred to the falls team for additional specialist input.

Staff did not fully understand their responsibilities with regard to safeguarding people from avoidable harm and abuse. They were able to describe how they would recognise different types of abuse, and how they would act on concerns. Comments from staff included, "I would report anything I was worried about, from the smallest bruise" and, "If I heard or saw anything I would report it straight away." However, one person reported concerns of a safeguarding nature to us and we contacted the local authority safeguarding team. Staff told us the person, "Always says that". The records did not provide information or guidance for staff when the person raised concerns.

Since the inspection, and in response to the concerns we raised, the registered manager contacted us to confirm they had provided guidance for staff.

Safe recruitment processes were completed. Staff completed an application form prior to employment. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

Requires Improvement

Is the service effective?

Our findings

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.

One person told us, "They tell us when they're going to help us, but I know they're so busy." The person told us they weren't usually asked if they agreed to the care that was given.

One person received their medicines covertly, in a cup of coffee. We were told by the member of staff this had been agreed with the GP. There were no supporting records to confirm how this decision had been reached and who was involved in the discussions.

The records did not provide detail about how consent was obtained, how best interest decisions were made and outcomes agreed. We saw consent forms in peoples' care records for bed rails and for the administration of the flu vaccinations. However, there were no other decision specific consent forms or records to evidence that decision making processes were followed. For example, the care records stated that people had been made aware that in giving implied or verbal consent this was a continuing process and not a one off. The records did not provide detail about what people were consenting to or how consent was to be achieved. One person received their medicines covertly. The records did not provide detail of the people involved in the discussions and decisions that had been made. For another person, the records stated on occasions when they were aggressive, they were to remain in their room. The person had capacity and there were no records to confirm they had agreed or consented to this. The registered manager told us they did not routinely use consent forms. They told us a mental health consultant had recently suggested these should be completed and so they were planning to introduce them into the home.

The above was a breach of Regulation 11 Health and Social Care Act (Regulated Activities) Regulations 2014.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

The registered person told us they planned to submit DoLS applications for eight people living at the home. One person at the home had a current authorised DoLS in place. The registered person had met the legal requirement to notify the Commission when an authorised DoLS was confirmed.

Staff completed an induction programme when they started in post. We spoke with a member of staff who had completed their induction. They told us they had not completed training on infection control or mental

health awareness. The registered person told us their training programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably trained to provide a high standard of care and support. We found the Care Certificate had not been fully implemented.

Staff told us they received individual performance supervisions, 'every now and then.' They told us they felt supported by the registered manager. The registered manager told us they aimed to undertake staff supervision meetings every two months. They told us these were not always completed at this frequency, and they were not always recorded. The registered manager told us they completed annual assessments of staff competency, as part of medicines management training. The checks were not recorded.

We looked at the training records and saw training had been completed for topics described as mandatory by the provider. The specific shortfalls in staff training for first aid and moving and handling, identified at our last inspection, had been addressed.

We spoke with people who were positive about the quality and choice of food available. Comments included, "The food is excellent here. I can't fault it. We get large portions," "I like the food, there's plenty of it and I enjoy it" and, "I'm vegetarian, but I do eat chicken and fish. They do cater for me, but I can also buy my own things. I buy my own fruit and like to make my own muesli."

People had access to drinks throughout the day, and were assisted by staff if needed. We saw meals being served to people in their rooms and in the dining room. Where people needed support in the dining room with their meals at lunchtime, this was not rushed and the mealtime was a pleasurable experience. Staff asked people if they were enjoying their meal and offered additional helpings. We checked on a person who ate their meal in their bedroom. There were no staff present when we checked the person. We spoke with a member of staff who told us the person usually managed their food well. Their care plan that was not dated stated, 'Needs a soft diet and staff must not leave the dining room as [Name of person] is at risk of choking.' The care plan did not reflect the care and support we were told the person needed.

Most people's weights were recorded, concerns were reported to the GP and actions were taken. This included the prescribing of food supplements if needed. For people unable to use the weighing scales, the registered manager told us they were not aware of the nationally recognised screening tool (MUST). This provides guidance about how to assess people who are not able to stand or be weighed.

We recommend the provider uses a nationally recognised tool is used to assess nutritional risks. As a result of this recommendation the registered manager contacted us after the inspection and told us they had started to assess people using the MUST tool.

People were referred to and had access to other external healthcare professionals. For example, records showed that people were seen by their GP, they attended hospital appointments and referrals were made to other health professionals. One person told us, "The staff do keep tabs on me. They check my hospital letters and keep an eye on my medication." Another person received on-going support from the community mental health team. The report from the most recent support visit had not been received by the home at the time of our visit. Another person had, we were told by the registered manager, been discharged by the community mental health team.

Requires Improvement

Is the service caring?

Our findings

Most of the people we spoke with told us that staff were kind, caring and respectful. One person told us, "The staff are very kind and very good" and, another person said, "All the staff are nice, they chat to me a lot. I can't thank them enough." Relatives spoke positively and comments included, "The staff know what [name of person who used the service] enjoys and they are so loving towards her" and, "Everyone, the manager and staff are all so approachable and kind."
However, one person told us, "The staff are average to be honest. They tolerate me."

During our visit, we observed positive interactions between staff and people using the service. People were treated with kindness and compassion. Staff spoke kindly to people and people responded in a positive way by smiling and chatting with staff. However, we heard the following when staff were speaking with one another, "Are you doing her today?" and, "Have you got [name of person]." One member of staff spoke with a person who used the service and said, 'I'm doing you later'." Whilst none of the comments made were said in an unfriendly manner, this was not a respectful way to speak about, or to people.

We saw that staff were gentle with people. For example, we saw a member of staff helping a person to put on their shoes. They said, "Here, let me help you, and then, "Can you just lift your foot up for me."

It was clear staff knew people well. One person said, "We all have a key worker and mine knows me quite well" and another person commented, "They're very gentle, they know me well and my life history."

People were not always supported to make choices and decisions. For example, one person had two wardrobes in their bedroom. They did not know why they had this additional furniture in their room. The wardrobe was full of clothes for another person living in the home. We asked the other person and they were not aware their clothes were being stored in another bedroom. They told us, "I wondered where all of my outdoor clothes were."

Staff were able to tell us how they made sure people's privacy and dignity was maintained. Comments from staff included, "I always close the door and tell people what I'm doing," and, "We make sure people have their privacy. If they're on the toilet for example, most people like a bit of privacy." All personal care took place behind closed doors.

We did note that some people had details of the personal care they needed displayed on the wall in their bedrooms. For example, in one person's room, a notice stated, 'Shower day Tuesday, to have help from two carers for all personal care. Manual handling belt to be used at all times. Unable to walk, wheelchair used. Helped into bed by late staff.' This did not communicate the person's care needs in a dignified way.

We met with relatives who visited during the days of our visit. We saw they were greeted by staff when they arrived in the home. There were no restrictions and relatives told us they were always made to feel welcome.

The home had received compliment and thank you cards and these were displayed in the entrance hall. Extracts from the cards we read included, 'Thank you to each and every one of you for the kindness to my Mum. Thank you for your caring attitude, your patience, your smiles, your friendliness, your calmness in times of crisis'. 'You are the nicest bunch of people I know' and, 'I will always remember the happy atmosphere there.'

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their individual needs. Individual needs were not always identified in care plans and we found a 'task orientated' approach to the provision of care, support and treatment. We spoke with people who told us they had not been involved in their care planning. One person told us, "I have a shower every Saturday although I don't really like them. I would prefer a bath." The care records did not provide detail about this person's preferences or choices. Bath/shower lists recorded peoples' allocated bath/shower day. The registered manager told us that no one in the home had baths because nobody liked them.

One section in the care plan was headed, 'Things that worry me.' One person stated, 'I worry about the pain I am in'. The care records did not provide information or guidance about the type of pain the person was in. The effectiveness of prescribed pain relief was not recorded.

Staff were kind in their approach with people and demonstrated they knew people well. However, this was not evident in the care records or, sometimes, in the way staff planned, described and discussed the care and support they provided for people. For example, the morning routine for staff, in preparation for providing personal care was to collect their allocation list of people they were providing personal care for that morning and to collect the incontinence pads needed. A table in the dining room had sets of pads on it. On the top of each set of pads was a handwritten note with the name of a member of staff and, the names of people they were allocated to provide personal care for.

The care plans did not always provide details about each person's individual needs. For example, one person's care plan stated they were incontinent and that toileting times were '8, 10, 12, 2, 4, 6, 8.'
A toileting chart in the dining room contained the names of the people in the home who were incontinent and the toileting times were all the same as above. We spoke with staff who told us they would take people to the toilet at other times if needed.

Care records did not provide information or details about how people were feeling and how they responded or participated in the care provided. For example, one person's records stated, 'Washed, creamed, dressed, padded, hair, bed, water.' The care plans did not provide detail about what the person could do independently and what and how they needed and preferred their care. The records confirmed the number of staff required to support the person. For example, 'Needs two for personal care.'

These were breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives who visited the home regularly told us they discussed the care for the person who used the service on a regular basis, and were kept up to date with any changes. One relative commented, "We don't have formal reviews but I have daily updates and [name of registered manager] or the staff would always let me know of any changes." The registered manager kept a separate record of significant conversations they had with relatives.

An activity programme was in place, and the weekly programme was displayed in the home. The programme included visits from external entertainers. During the first morning of our visit, the activity organiser provided a 'memory joggers' activity. During the afternoon, a musical session was provided by a volunteer from 'Bristol ageing Better' a voluntary organisation that provides support for older people. They visited each week and provided activities. We saw that nine people participated and enjoyed the singing and there was lots of laughter throughout the day. The registered person told us that one to one visits took place with people in their rooms. These visits were not recorded.

People and their relatives told us they would feel comfortable raising issues of concern with the registered manager. One person told us, "I did speak to the manager about the lack of hot water but they already knew about it and had called the plumber." A complaints procedure was available and on display in the home.

Inadequate

Is the service well-led?

Our findings

We spoke with the registered person about the quality assurance systems that checked the quality of the service provided. We discussed audits to ensure risks to people's health safety and welfare were identified, and actions taken where required to mitigate risks. We found that where audits had been completed, they had not identified the significant shortfalls we found and have reported on, mainly in the safe section of this report. We also found audits had not been accurately completed.

The registered manager had completed a medication audit in February 2017. The audit did not identify any shortfalls or actions that were needed. The registered manager told us since this time they and the deputy manager checked the medicines at random. They told us they did not record these checks. The shortfalls we have reported on had not been identified. The registered manager told us as part of their quality monitoring and checking they assessed staff the competence of staff who administered medicines. These checks were not recorded.

The staff supervision and training records were not fully completed. They did not provide confirmation that staff were sufficiently trained and supported to carry out their roles.

In addition we found peoples' records were not always securely stored. Bath, shower and toilet lists with peoples' names were stored insecurely on the top of a cupboard in the dining room.

Since the inspection, the registered manager contacted us and told us they had discontinued the use of the task lists noted above.

The registered manager had completed a 'person centred care audit checklist' in February 2017.
The audit stated there were no shortfalls and included confirmation, for example, that peoples' likes and dislikes were recorded and that formal care reviews were completed. We found these had not been fully recorded and the shortfalls we have reported on had not been identified.

A health and safety audit was completed in February 2017. None of the significant shortfalls we found with regard to the safety of the premises had been identified.

The infection control policy in use was dated 2006. Guidance had been provided by the Public Health department since this date. The registered manager told us, and we saw they were in the process of updating policies and procedures. An infection control audit was completed in February 2017. No shortfalls were identified.

The annual audit completed with the provider in January 2017 included checks for general safety, housekeeping, lighting, heating and water. None of the shortfalls we found had been identified and some had been incorrectly reported. For example, one of the areas stated the legionella 'flushing policy' was being completed. We found it had not been completed. Another area confirmed 'yes' in response to, 'Is the temperature of hot water in client areas less than 43 degrees centigrade' The temperatures were not

controlled. This was of such concern to us during our visit, we asked the registered manager to remove plugs from the baths, as an interim measure to mitigate the risks of people being submersed in scalding water.

The above were breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to see the manager if they needed to. We received positive feedback from relatives about the management and running of the home. Comments included, "[Name of registered manager] is always available if we need her", "It's a fantastic place" and, "The manager is so approachable and kind."

One person told us, "We used to have coffee mornings and resident meetings, but I can't remember when the last one was. Occasionally we have committee meetings about food to discuss menu changes."

People and their relatives had been given the opportunity to provide feedback about the service. The most recent survey had been completed by five relatives and 19 people who used the service. The registered manager told us the most common concern or issues raised was the limited availability of car parking. The registered manager told us that staff no longer drove to work. This had made the car park more accessible for visitors.

Staff spoke positively about the registered manager and told us Whiteladies was a good place to work. Comments included, "Morale is alright. Most of the time we're all pretty cheerful," and, "We get a lot of support from [name of registered manager]. If we're short she comes out of the office and gives us a hand."

Staff told us they had the opportunity to express their views, and that they felt listened to. Staff meetings were held on a regular basis. One member of staff did tell us, "It would be nice to get a bit more praise. We always get told if things are wrong, but not always when we've done well."

The registered person understood their responsibilities with regard to notifications that are legally required to be sent to the Commission.

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 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 Care and treatment was not personalised and did not always reflect people's individual needs. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always protected in line with the Mental Capacity Act 2005. Consent to care and best interest decision making was not always obtained in line with legal requirements. (1)

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 12 HSCA RA Regulations 2014 Safe care and treatment Equipment was not always used correctly used. Risk assessments and risk management plans were not fully completed. Staff did not always have the skills and experience to deliver safe care. Plans were not in place to mitigate the risks to peoples' safety. The premises were not safely maintained or safe to use. Medicines were not safely managed. Insufficient measures were in place to prevent, detect and control the spread of infection. (1) (2) (a) (b) (c) (d) (e) (f) (h)

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not in place to assess, monitor and mitigate the risks to peoples' safety. Quality assurance systems were not in place to assess, monitor and make improvements to the quality of the service. Peoples' care records were not always securely

stored. Staff training records were incomplete.

(1) (2) (a) (b) (d)

The enforcement action we took:

We issued a Warning Notice