Langton Care Limited

The White House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The White House is a large detached house set on the outskirts of the coastal town of Teignmouth. The home is registered to provide accommodation and personal care for up to 22 older people who may be living with a dementia or physical disability.

At the time of the inspection there were 22 people living at the home. The home offers both long stay and short stay respite care. The White House does not provide nursing care. Where needed this is provided by the community nursing team.

This inspection took place on the 19 and 20 April 2017; the first day of the inspection was unannounced. The home was previously inspected in February 2015 when it was found to be meeting the requirements at the time.

The home had a registered manager. However, they were not available during this inspection as they were on annual leave. 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.

There was some good practice in relation to the management of medicines. However, we found improvements were needed in relation to record keeping, storage and the deposal of unused prescribed topical applications, such as creams, ointments, and gels when they were no longer required. For example, in the main lounge we found an unlocked wooden cabinet that contained a number of prescribed topical applications dating back to 2013 and 2014, which should have been return to the local pharmacy for disposal. Immediate action was taken to address these issues. People received their prescribed medicines when they needed them and in a safe way. Staff had received training in the safe administration of medicines.

People were not always protected from the risk of harm. We found a number of toiletries and chemicals had been left out and accessible. Risk assessments had not been completed to show this was safe, despite these potentially presenting a risk to people living with dementia who might ingest them accidentally. Immediate action was taken to address these issues. Other risks to people's health, safety, and well-being had been assessed and regularly reviewed. People's care plans contained detailed risk assessments and management plans, which covered a range of issues in relation to people's needs. For example, risks associated with skin care, poor nutrition and the risk of falls due to reduced mobility had all been assessed.

Staff displayed a good understanding of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding (DoLS). People were encouraged to make choices and were involved in the care and support they received. Some people did not have the mental capacity to make complex decisions about their health and welfare. Where decisions had been made in a person's best interests these were not always

being fully documented. We raised this and were assured action would be taken to address this.

The home's quality assurance and governance systems were not effective. Although some systems were working well others had not identified the concerns we found during this inspection.

People said they felt safe and well cared for at The White House, their comments included "I feel safe here they [staff] look after me well." Another person said, "I do feel safe, it's my home." Relatives told us they did not have any concerns about people's safety. People were protected from abuse and harm. Staff received training in safeguarding vulnerable adults and demonstrated a good understanding of how to keep people safe. There was a comprehensive staff-training programme in place. This included first aid, pressure area care, infection control, moving and handling, and food hygiene.

People told us staff treated them with respect and maintained their dignity. Throughout the inspection, there was a relaxed and friendly atmosphere within the home. Staff spoke about people with kindness and compassion. People and relatives told us they were involved in identifying their needs and developing the care provided. People's care plans were informative, detailed, and designed to help ensure people received personalised care.

People spoke positively about activities at the home and told us they had the opportunity to join in if they wanted. The home had a programme of organised activities that included arts and crafts, music sessions, exercise classes, card games, and quizzes.

People, relatives and staff spoke highly of the management team and told us the home was well managed. Staff described a culture of openness and transparency where people, relatives and staff, were able to provide feedback, raise concerns, and were confident they would be taken seriously.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risk of harm because risks associated with their living environment had not identified, managed or mitigated.

People received their medicines as prescribed however, topical applications, such as creams, ointments or gels were not always stored safely or disposed of correctly.

People were safe as the provider had systems in place to recognise and respond to allegations of abuse.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Is the service effective?

Good

The service was effective.

People were supported to make decisions about their care by staff who had a good understanding of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, records we saw did not always reflect this.

People were cared for by skilled and experienced staff who received regular training and supervision, and were knowledgeable about people's needs.

People's health care needs were monitored and referrals made when necessary.

People were able to choose their food and drink and were supported to maintain a balanced healthy diet.

Is the service caring?

Good

The service was caring.

People were supported by staff that promoted their independence and respected their dignity.

People's privacy was respected and they were able to make choices about how their care was provided and where they spent their time.

People and their relatives were supported to be involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People were confident that should they have a complaint, it would be listened to and acted on.

People were involved in all aspects of their daily lives. Staff took account of people's previous lifestyles and wishes when planning and delivering care.

There was a programme of activities and social events, meaning people were well occupied and stimulated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have an effective quality assurance system in place to assess and monitor the quality of care being provided.

Records were not always well maintained.

There was an open culture where people and staff were encouraged to provide feedback, which was used to drive improvements.

Staff felt they received a good level of support and could contribute to the running of the home.

The White 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 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.

This inspection took place on the 19 and 20 April 2017; the first day of the inspection was unannounced. One adult social care inspector and an expert by experience (ExE) carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information held about the home. This included previous inspection reports and Statutory Notifications we had received. A statutory notification is information about important events, which the home is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the home for instance, what the home does well, as well as any improvements they plan to make.

During the inspection, we spoke with 11 people individually and met with most people who used the service. On this occasion, we did not conduct a short observational framework for inspection (SOFI) because people were able to share their experiences with us. However, we did use the principles of this framework to undertake a number of observations throughout the inspection.

We looked at care records for five people to check they were receiving their care as planned as well as how the home managed people's medicines. We reviewed staff recruitment, training and supervision files for three staff. We looked at the quality of care and support provided, as well as records relating to the management of the home. We spoke with seven members of staff, and the deputy manager. We looked around the home, including some people's bedrooms with their permission, as well as the grounds. We also spoke with five relatives of people currently supported by the home. Following the inspection, we sought and received feedback from three health and social care professionals who had regular contact with the home.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm as the risks to people's safety had not been fully assessed, managed, or mitigated, in relation to their living environment. On the first day of the inspection, we looked around the home with the deputy manager. We found the upstairs and downstairs bathroom/toilets as well as a cabinet on the upper floor had a number of toiletries left out and accessible. Risk assessments had not been completed to show this was safe, despite these potentially presenting a risk to people living with dementia who might ingest them accidentally. In addition, we found chemicals used for the fish tank in the main lounge; these should have been locked away in accordance with the Control of Substances Hazardous to Health (COSHH). We raised our concerns with staff who took immediate action was and ensured that all chemicals were stored in accordance with the regulations.

There was some good practice in relation to the management of medicines. However, we found improvements were needed in relation to record keeping, storage and the deposal of unused prescribed topical applications, such as creams, ointments, and gels when they were no longer required. For example, in the main lounge we found an unlocked wooden cabinet that contained a number of prescribed topical applications (creams, ointments, and gels) dating back to 2013 and 2014 which should have been returned to the local pharmacy for disposal. When we raised this immediate action was taken and arrangements were made for the items to be properly stored within their medication room until they could be returned to the local pharmacy.

Some people were prescribed medicines to be given "when required" such as for the management of pain. Care plans and medicine records lacked guidance for staff to assist their decision-making about when this type of medicine should or could be used. This information is necessary where people may not be able to verbalise how they are feeling, and provides staff with information and guidance, such as symptoms a person may display if they were in pain.

Some people were prescribed topical applications, such as creams, ointments, and gels. However, there were no body maps or detailed information on where to apply these or why they had been prescribed. This meant staff could not be sure if people had their topical applications applied as prescribed by their GP. We raised these issues on the first day of inspection. When we returned for the second day, a new system had been implemented.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People told us they felt safe and well cared for at The White House. One person said, "I feel safe here they [staff] look after me well." Another person said, "I do feel safe it's my home." Relatives told us they did not have any concerns about people's safety. One relative said, "People always appear safe and well looked after". We saw people were happy to be in the company of staff and were relaxed when staff were present. A visiting healthcare professional said people always appeared to be happy and well cared for.

People were protected from the risks of abuse and avoidable harm. Staff had received training in safeguarding adults and whistleblowing and knew what to do should they have had concerns that people were at risk of harm. Staff demonstrated a good understanding of how to keep people safe and how and who they would report concerns to. Staff were able to identify different types of abuse and signs that someone may be at risk of harm. The policy and procedures to follow if staff suspected someone was at risk of abuse or harm was displayed and assessable to staff. This contained telephone numbers for the local authority and the Care Quality Commission.

Recruitment procedures were robust and records demonstrated the provider had carried out the necessary checks to help ensure that staff employed, were suitable to work with people who use care and support services. These included checking applicant's identities, obtaining references, checking gaps in people's employment history and carrying out DBS checks (police checks).

People living at the home, their relatives and staff all told us they felt there were sufficient staff on duty to meet people's care needs. One person said, "There is always someone around when I need them." Relatives we spoke with told us they did not have any concerns about the staffing level at the home. On the day of the inspection, there were three care staff on duty, which were supported by a senior care worker. Staff were visible throughout the inspection and people's call bells were answered quickly. The deputy manager and a number of ancillary staff such as housekeepers, chef, kitchen, laundry, and administrative assistants were also on duty. During the night, people were supported by two waking night staff. The deputy manager told us staffing levels were determined according to people's needs and the rota adjusted accordingly. Staff confirmed that when people's care needs increased, for instance, if they were unwell, staffing levels were increased to help ensure people's care needs were met safely. However, we found that the provider did not have a system for determining how many care staff were needed in relation to the number of people who lived in the home and their dependency needs. On the second day of the inspection, the provider had introduced a new dependency tool.

Other risks to people's health, safety, and well-being had been assessed and regularly reviewed. People's care plans contained detailed risk assessments and management plans, which covered a range of issues in relation to people's needs. For example, risks associated with skin care, poor nutrition and the risk of falls due to reduced mobility had all been assessed. Risk assessments contained information about the person's level of risk, indicators that might mean the person was unwell or at an increased risk and action, staff should take in order to minimise these risks. For instance, one person's skin integrity had been assessed as being at increased risk. This person had a specialist pressure reliving mattress in place and staff had been instructed to support them to change position every two hours, which we saw happening.

People were kept safe as the registered manager and staff carried out a range of health and safety checks on a weekly and monthly basis to ensure that any risks were minimised. For example, fire alarms, fire doors, emergency lighting, equipment, and infection control. Records showed that equipment used within the home was regularly serviced to help ensure it remained safe to use. However, we found the systems in place were not robust, as they had failed to identify any of the risks associated with the environment as detailed above.

Accidents and incidents were recorded and reviewed by the registered manager. They collated the information to look for any trends that might indicate a change in a person's needs and to ensure the physical environment was safe. Each person had a personal emergency evacuation plan (PEEP) and the provider had contingency plans to help ensure that people were kept safe in the event of a fire or other emergency. Staff were trained in first aid and first aid boxes where easily accessible around the home.

Good

Is the service effective?

Our findings

Most of the people who lived at the White House were living with a dementia or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. We checked whether the home was working within the principals of Mental Capacity Act 2005 (MCA). We found that although the staff showed a good understanding of the Mental Capacity Act 2005 (MCA) and their role in maintaining people's rights to make their own decisions, people's records did not show this

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.

Records showed and staff confirmed they had received training in MCA and throughout the inspection, we observed staff putting their training into practice by offering people choices and respecting their decisions. Staff told us how they supported people to make decisions about their care and support. For instance, supporting people to maintain a balanced healthy diet or by encouraging people to seek advice from healthcare professionals.

Whilst we saw staff obtaining people's consent, we found people's records did not reflect the same level of understanding. Where a person's capacity to make a decision was in doubt, we saw staff had assessed the person's capacity. However, records showed that people's capacity had not been assessed in relation to a specific decision. Where decisions had been made in people's best interests, these were not being recorded properly. This meant we were unable to tell, if decisions were specific, made in consultation with appropriate people, such as relatives, or were being reviewed.

Whilst it was acknowledged that people's records did not contain sufficient information to demonstrate the home was working within the principals of the Mental Capacity Act. We were assured immediate action would be taken to address this.

We recommend the provider seek advice from a reputable source in relation to recording and documenting people's mental capacity and best interests decisions.

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 home was working within the principles of the MCA. The home had a keypad system in operation, which prevented people, who would be unsafe, from leaving the home without support. However, not everyone living at the home had been assessed as unsafe to leave. These people were given the keypad number to the front door, ensuring their legal rights were protected and they were not deprived of their liberty. Where people had been identified as having their rights restricted, we saw DoLS applications had been made to the local authority.

People and their relatives told us, they were supported well and felt that the staff had the skills and knowledge to meet their needs. One person said, "They all know what they're doing." Relatives we spoke with felt staff were competent in their roles one relative told us, "All the staff do an incredible job."

Records showed new staff undertook a detailed induction programme, which followed the Skills for Care framework, including the Care Certificate. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. There was a comprehensive staff-training programme in place and staff confirmed they received regular training in a variety of topics. These included dementia care, first aid, infection control, moving and handling, food hygiene, safeguarding, and Mental Capacity (MCA). Other more specialists training included palliative care [care of the terminally ill] and pressure sore prevention.

Staff received regular supervision and annual appraisals with a named supervisor. Supervision sessions were planned every two months and each identified a different topic to be discussed with staff to aid their learning and understanding for instance, safeguarding, confidentiality, and respecting and protecting people's dignity. Staff told us supervision gave them opportunity to discuss all aspects of their role and professional development with their line manager. The registered manager and senior staff assessed staffs' knowledge by observing their practice and recording what they found. Staff told us they found this style of supervision very useful as it gave them the opportunity to discuss and identify any gaps in their knowledge or raise concerns.

People were able to see a range of health care services when needed, and had regular contact with dentists, opticians, chiropodists and GPs. People's care plans contained details of their appointments. Where changes to people's health or wellbeing were identified, records showed staff had made referrals to relevant healthcare professionals in a timely manner. For instance, records showed where people had needed the specialist advice of dietician's or speech and language therapy (SALT); referrals had been made in a timely manner. A visiting health care professional told us they had no concerns about the care provided by the home, and staff made referrals quickly when people's needs changed.

People told us they enjoyed the meals provided by the home. Comments included, "the food is good", "very nice," and "I can't complain." People were able to have their meals in the dining room, the lounge or in their own rooms if they wished. People who did not wish to have the main meal could choose an alternative. The chef and kitchen assistants told us they were provided with detailed guidance on people's preferences, nutritional needs, and allergies and there was a list of people's dietary requirements in the kitchen. We heard staff offering people choices during meal times and tea, coffee, and soft drinks were freely available.

We observed the lunchtime meal people sat in small groups and staff sat with people providing assistance where necessary. Where people needed assistance, this was provided appropriately and discreetly. Meals times were relaxed, social occasions were people and staff engaged in conversation, and light-hearted banter whilst enjoying their meals. Care records highlighted where risks with eating and drinking had been identified. For instance, where people required a soft or pureed diet, this was being provided. Each food item was processed individually to enable people to continue to enjoy the separate flavours of their meals.

Good

Is the service caring?

Our findings

People told us they were happy living at The White House. One person said, "The staff are really kind and friendly and they will do anything for you." Another person said, "I have only lived here for a short time, but I can't find anything bad here and I've made lots of friends." Relatives were complimentary about the staff and the way in which they met people's needs. One said, "They really are very good here, all the staff are very caring, friendly and kind."

There was a relaxed and friendly atmosphere within the home. Staff spoke fondly about people with kindness and affection. Staff knew how each person liked to be addressed, and consistently used people's preferred names when speaking with them. People responded well to staff and we observed a lot of smiles, laughter, and affection. There was genuine warmth between staff and people they supported. People told us they were happy with the care and support they received. One person said, "I'm happy here, all the staff are friendly." Another said, "They [staff] are so lovely, nothing is too much trouble." Staff told us they enjoyed working at the home. Comments included "it's a really good place to work" and "We all want what's best for people."

Information about people's needs and preferences were obtained and recorded as part of their pre-admission assessment. People's care plans were clear about what each person could do for themselves and how staff should provide support. People were supported by staff that knew them well. They were able to tell us about people's preferences and personal histories. For example, staff knew what people liked to eat and when they liked to get up and go to bed. People looked, well-cared for, and had their personal needs met in a way that suited them. People told us they were involved in making everyday decisions about their care and support and made choices each day about what they wanted to do and how they spent their time. Relatives told us they had been given the opportunity to contribute to and discuss their relation's care plans. One relative said, "They always let me know what's happening and if they can't get hold of me they always make a point of telling me when I visit."

People felt their views were listened to and respected. They said staff always treated them respectfully and encouraged them to remain as independent as possible. When people needed extra support this was provided in a considerate way, which did not make them feel rushed. Throughout the inspection, we saw and heard people being supported, staff spoke with them in a calm, respectful manner, and allowed people the time they needed to carry out tasks at their own pace. People told us that staff respected their privacy and we saw that staff knocked on people's doors and waited for their response before entering their rooms. People's bedrooms were personalised and furnished with things that were meaningful to them. For instance, photographs of family members, treasured ornaments, or pieces of furniture. People were encouraged and supported to maintain contact with their relatives and others who were important to them. Throughout the inspection, we saw relatives coming and going, spending time with their loved ones in the communal areas or the person's own bedroom.

People were supported at the end of their lives by staff who received specialist training. We saw a family member had recently wrote to the home and expressed their appreciation of the way staff had treated their

relative, saying "You all showed [my relative] such kindness, and made a very difficult time more bearable. People, who wished to, had made advanced directives detailing their preferences for the end of their lives and these were documented in their records.

Good

Is the service responsive?

Our findings

People and their relatives, were involved in identifying their needs and developing the care provided. The registered manager carried out an initial assessment of each person's needs before and after they moved into the home. This formed the basis of a care plan, which was further developed with the person, their relatives after the person moved in, and staff had got to know them.

People's care plans were personalised and provided staff with detailed guidance about each person's specific needs. Information was provided about what the person could continue to do for themselves and how they liked to be supported. Each section of the plan covered a different area of the person's care needs, for example, personal care, mobility, physical health, continence and skin care, communication and mental health and emotional support. Important information, such as allergies and health conditions was easily available for staff at the front of the care plan. People's care plans were informative, easy to follow, accurately reflected people's needs, and reviewed monthly or as people's needs changed. Staff told us that people, who were able, were asked to be involved in planning and reviewing their own care. Where people lacked the capacity to make a decision for themselves, staff involved family members or other advocates in the review of their care. People were given the opportunity to sign their care plans if they wished. However, records we saw did not always reflect this.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us detailed information about people's backgrounds and life history from information gathered from families and friends. Each person's care plan contained a life story, which covered the person's life history. This gave staff the opportunity to understand a person's past and how it could influence who they are today. Relatives told us they had been asked to share life history information and provided photographs were possible. One relative said, "They asked me what's was important to my wife, her likes and dislikes."

Some people needed support to manage long-term health conditions, for instance, diabetes. We saw the registered manager had consulted with the person's GP and provided staff with information on how to recognise signs and symptoms that would indicate this person was becoming unwell and what action staff should take. Where people had specific needs relating to living with dementia, guidance was provided for staff in how best to support people. For instance, one person was known to become distressed and anxious. The home had sought guidance from the 'older person's mental health team' and developed a plan for staff to follow to support this person's well-being and minimise the impact this might have. Staff were able to describe how they supported this person during these times.

People were supported to follow their interests and take part in a range of social and leisure activities. Each person's care plan included a list of their known interests and staff supported people on a daily basis to take part in things they liked to do. People who wished to stay in their rooms were regularly supported by staff in order to avoid them becoming isolated. People spoke very highly of the level of activities and entertainment provided by the home. One person said, "There is always something going on." Another person told us, "I always join in the activities,

I like the singing most." We saw a range of activities were available including music therapy, arts and crafts, arm chair exercises, board games and quizzes.

Activities were designed to encourage social interaction, provide mental stimulation and promote people's physical and spiritual well-being. The home produced a monthly activities programme, which was displayed within the home, and informed people about upcoming events. On the first day of the inspection, we saw the home had arranged for musical entertainment, several people join the staff dancing and singing nostalgic songs, which they clearly enjoyed.

There were numerous thank you cards and letters which were very complimentary and included comments like, 'Thank you for caring for our mum,' 'We were treated with dignity and respect by all,' 'We couldn't have wished for a better place,' and 'Please accept our heartfelt thanks to you and your wonderful staff.'

People and relatives were aware of how to make a complaint, and felt able to raise concerns if something was not right. One person said they would speak to [person name] the deputy manager if they were unhappy. Relatives told us the registered manager was always available and they would feel able to approach them or staff if they had any concerns. One relative said, "I'm confident that if I ever had to raise a concern the staff would be deal with it immediately and professionally." The home's complaints procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated, and responded to.

Requires Improvement

Is the service well-led?

Our findings

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality of the services provided at The White House. We found the provider and registered manager used a variety of quality management systems to monitor the services provided and drive continuous improvements. These included a range of audits and spot checks, for instance, checks of; environment, medicines, care records, accidents and incidents, finances and people's wellbeing. These checks were regularly completed and monitored to help ensure and maintain the effectiveness and quality of the care provided. In addition, senior staff completed a 'critical incident' report each day to record important events, such as anyone falling or whether anyone had become unwell, as well as essential information that had to be passed from one shift to another.

Although some systems were working well others had not identified the concerns we found during this inspection. For instance, quality assurance systems had failed to identify risks associated with people's living environment and therefore these risks had not been managed or mitigated.

Where people had been assessed as not having capacity and decisions had been made in a person's best interests, these were not being recorded properly.

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

The registered manager had not always notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included the notification of safeguarding concerns. We discussed this with the deputy manager who assured us this had been an oversight. Following the inspection, the required notifications were submitted.

This was a breach of regulation 18 of the Care Quality Commission (registration) Regulation 2009.

People their relatives and staff told us the home was well managed and described the homes management team as open, honest and approachable. All of the people and relatives we spoke with during this inspection said they would recommend the home to others. One person said, "I am very happy here and I can talk to [deputy managers name] about anything." A relative said, "I'm very happy with the care [person name] receives, we have every confidence in the staff and management team." Staff were positive about the support they received and told us they felt valued by the homes management team. They described a culture of openness and transparency where people and staff, were able to provide feedback and raise concerns.

The management team had a clear vision for the home, which was to provide and maintain a high standard of personalised care in a warm and friendly environment. Choice, independence, dignity, privacy and fulfilment were seen as people rights and respected by staff who were passionate about supporting and enabling people to lead fulfilling lives. Staff had a clear understanding of the values and vision for the home,

had a real sense of pride in their work, and spoke passionately about providing good quality care.

The management and staff structure provided clear lines of accountability and responsibility. Staff knew whom they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through daily handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns. Regular staff meetings enabled staff to discuss ideas about improving the home. The management team used these meetings to discuss and learn from incidents; highlight best practice and challenge poor practice were it had been identified. We looked at the minutes of these meetings and saw the staff and management team had discussed information relating to the kitchen, laundry, care planning and activities.

People were provided with a copy of the home's service user guide and statement of purpose when they moved into The White House so they were clear about the service provided. The homes notice boards contained useful information for people and relatives, for instance, copies of the homes complaint procedure, compliments, information about what people should expect form a good care home and a copy of the home activity programme.

People told us they were encouraged to share their views and were able to speak to the registered or deputy managers when they needed to. Resident and relatives meetings where held regularly. We looked at the minutes of these meetings; records showed people were encouraged to share their feedback about all aspects of the home. For example, menus, activities, cleanliness and staffing as well as any maintenance issues. The registered manager used these meetings to keep people informed of forthcoming events and discuss any planned changes to the home. For instance, ensuring that people were kept up to date with the homes refurbishment and development plans.

The registered manager annually sought people's views by asking people, relatives, and external professionals to rate the quality of the services provided by the home. For example, management, staffing, environment, and complaints. We looked at the results from the latest survey undertaken in January 2017, and found the responses of the people surveyed were positive with 95% of people rating the home as 'outstanding' or 'good'. Comments included; "I am always impressed by the high standard of staff", "I have no reason to complain" and "although my relative has only recently moved into the home I am more than satisfied with the situation and find the staff helpful and co-operative."

The deputy manager kept their knowledge of care management and legislation up to date by using the internet and attending training sessions. They were aware of their responsibilities under Regulation 20 of the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.

Records were stored securely, when we asked to see any records, the deputy manager was able to locate them promptly.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not being protected from risks associated with the environment. People were not always protected by the safe management of topical applications, such as creams, ointments or gels. Topical application were not always stored safely or disposed of correctly. Regulation 12 (2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not ensuring people were protected by having systems and processes to effectively assess monitor and improve the quality and safety of the services provided. Records were not accurate, complete, or well maintained. Regulation 17 (1) (2) (a) (b)