Janes Care Homes Limited

# The White House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| 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

This inspection took place on 3 May 2016 and it was unannounced. At the last inspection in May 2014, we asked the provider to take action to make improvements to the completion and accuracy of people's care records and to the cleanliness and infection control procedures of the service, and this action has been completed.

The White House provides accommodation and care for up to 28 people with a variety of social and physical needs, some of whom may be living with dementia. At the time of our inspection there were 15 older people living at the service.

The manager registered by the Care Quality Commission is no longer employed by the service but has not cancelled their registration. A new manager has been appointed but is not yet registered. 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 felt safe in the service. Staff understood their responsibilities with regards to safeguarding people and they had received effective training. Referrals to the local authority safeguarding team had been made appropriately when concerns had been raised.

There were sufficient numbers of staff on duty to meet people's needs and promote their safety at all times. Safe recruitment processes were in place and had been followed to ensure that staff were suitable for the role they had been appointed to prior to commencing work. Staff were trained and completed an effective induction programme when they commenced work at the service.

People's needs had been assessed and care plans took account of their individual needs, preferences and choices. There were personalised risk assessments in place that gave guidance to staff on how individual risks to people could be minimised. Care plans and risk assessments had been regularly reviewed to ensure that they were reflective of people's current needs.

People's health care needs were being met and they received support from health and medical professionals when required. Medicines were managed safely and audits completed. People were supported to make choices in relation to their food and drink and a varied menu was offered.

Staff were kind, friendly and respectful. People's privacy and dignity was promoted throughout their care. Staff knew people's needs and preferences and provided encouragement when supporting them. People were encouraged to participate in activities and received relevant information regarding the services available.

The management team were approachable and staff felt supported in their roles. People and staff knew who to raise concerns with and there was an open culture. People and their relatives were asked for their feedback on the service and comments were encouraged. The provider completed quality monitoring audits however it was not always clear how these were used to drive improvements in the service or where actions required to be taken were recorded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People told us that they felt safe. There were systems in place to safeguard people from the risk of harm and staff had an understanding of these processes.

People had personalised risk assessments in place and action was taken to reduce the risk of harm from identified hazards.

People's medicines were managed safely.

There were sufficient members of staff on duty at all times and safe recruitment processes in place.

### Is the service effective?

Good

The service was effective.

Staff were trained and received regular supervisions and appraisals to assist in identifying their learning and development needs

People were asked to give consent to the care and support they received.

People were supported to meet their health needs and had access to a range of health and medical professionals.

People were complimentary about the meals that were provided at the service and a varied menu was in place.

### Is the service caring?

Good

The service was caring.

Staff were kind, friendly and respectful.

People's privacy and dignity were promoted by staff.

Staff understood people's needs and respected their choices.

## Is the service responsive?

Good

The service was responsive.

Detailed care plans which reflected people's needs and preferences were in place and were consistently reviewed.

People were offered support to participate in activities.

There was an effective system to manage complaints.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was no longer employed at the service. The manager in post had not yet completed their registration.

Quality monitoring audits had been completed regularly but it was not clear how these were used to drive continuous improvements or where any actions required to be taken were recorded.

There was a clear management structure of senior staff. There was an open culture amongst the staff team and staff felt management were supportive and approachable.

People, their relatives and staff were encouraged to give feedback on the service provided.

# 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 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 3 May 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection, we reviewed the information available to us about the service such as information from the local authority, information received about the service and notifications. A notification is information about important events which the provider is required to send us by law. We found that no recent concerns had been raised.

During the inspection we spoke with seven people who lived at the service, one care worker, two senior care workers, one cook, the manager of the service and the operations manager for the provider organisation.

We carried out observations of the interactions between staff and the people living at the service. We reviewed the care records and risk assessments of ten people who lived at the service, and also checked six medicines administration records to ensure these were reflective of people's current needs. We also looked at four staff records and the training records for all the staff employed at the service to ensure that staff training was up to date. We reviewed information on how the quality of the service was monitored and managed to drive future improvement.

Good

# Is the service safe?

## Our findings

When we inspected the service in May 2014 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found some areas of the service where appropriate standards of cleanliness had not been maintained. We also found that equipment and the physical environment had not been maintained to a sufficient standard to enable it to be effectively cleaned or it presented a hazard to people. We asked the provider to take action to make improvements to the cleanliness and maintenance of the service and the equipment in use, and this action has been completed.

People told us that their bedrooms were cleaned to a good standard and our observations confirmed this. We found that communal areas including toilets and bathrooms had been cleaned and contained ample supplies of hand soap and handtowels. Housekeeping staff had access to sufficient equipment and materials required to complete tasks and a schedule was in place to ensure all areas of the service were cleaned regularly. Care staff had access to a good supply of protective equipment for the tasks they were carrying out, for example, disposable gloves and aprons when assisting people with personal care. We observed that they wore these when required and items were disposed of appropriately once used. Records we viewed confirmed that cleaning tasks had been completed in accordance to the schedule in place.

There was a maintenance schedule in place for the environment and we saw that repair works had been completed promptly when identified. We observed maintenance works being completed in the service on the day of our inspection and the manager described how these improvement works were to continue in the future.

People we spoke with said that they felt safe and secure living at the service. One person said, "I do feel safe." Another person told us, "I do feel safe here; they do their best for me."

All the members of staff we spoke with told us they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of concerns they would raise. They were also aware of reporting to the local authority or other agencies and demonstrated a good understanding of these processes. One member of staff said, "I would raise any concerns about people with the manager, although I know the form we have to complete for the local authority if they aren't around." Another member of staff said, "I would talk to the senior or the manager. I know we have to speak up if we are worried about anyone." Training records for staff confirmed that they had undergone training in safeguarding people from the possible risk of harm. There was a current safeguarding policy and information about safeguarding including the details of the local safeguarding team was displayed in the entrance hallway and in the staff room. Records showed that appropriate referrals had been made to the local authority where required.

Personalised risk assessments were in place for each person who lived in the service which addressed identified hazards they may face. One person told us, "They always make sure things are safe before they use them." The manager told us that risk assessments were reviewed monthly to ensure that the level of risk to people was still appropriate for them, taking into account any changes in people's needs. Any actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. This

included identified support regarding nutrition and hydration, continence care, falls and skin integrity. For some people, these also identified specific support with regards to their mobility and the steps that staff should take and the equipment to use to keep people safe.

Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of ways. These included looking at people's care plans and their risk assessments and by talking about people's needs at staff handovers. One member of staff told us, "We hold a really detailed handover, which is all written down and recorded, and discuss any issues that people may have had that day. We know then that the next shift are aware of how people are feeling or if anyone is experiencing a difficult day and needs closer observation or more help." A member of staff who had recently started working at the service told us, "I shadowed experienced staff before I went on shift so I had the chance to watch how to do the work safely and how to work with the people."

A record of all incidents and accidents was held, with evidence that the manager had reviewed each report and appropriate action had been taken to reduce the risk of recurrence. Where required, people's risk assessments were updated to reflect any changes to their care as a result of these so they continued to have care that was appropriate for them.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments, the communal areas and the presence of stairs in the building, first aid provision, the maintenance and inspection of mobility equipment and the security and access to the building. People living at the service had Personal Emergency Evacuation Plans (PEEP's). Information and guidance was displayed in the entrance hallway to tell people, visitors and staff how they should evacuate the service if there was a fire.

There was enough staff to meet people's needs during our inspection. One senior member of staff told us, "There are enough of us, as the senior I help out and we get done on time." We observed that staff were available to meet the needs of people living in the service when required or requested. The manager used a dependency tool to assess the level of need of all the people living in the service and the support they required. This was reviewed on a monthly basis to determine staffing levels prior to completion of the staff rota and took into account any changes to people's needs or any new admissions to the service. We reviewed past rotas and found that there was consistently the required number of staff on duty as determined by the dependency tool.

We looked at the recruitment files for four staff including one care worker that had recently started work at the service. We found that there were robust recruitment and selection procedures in place. Relevant pre-employment checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

People we spoke with confirmed they received their medicines as prescribed and that staff administered additional medication, including pain killers when they asked for them. One person told us, "I have my tablets on time." Another person told us, "I don't have many tablets but I get them when I need them in the day." There were effective processes in place for the management and administration of people's medicines and there was a current medicines policy available for staff to refer to should the need arise. We reviewed six records relating to how people's medicines were managed and they had been completed properly. Medicines were stored securely and audits were in place to ensure these were in date and stored according to the manufacturer's guidelines. A senior member of staff explained to us how regular audits of medicines were carried out so that all medicines were accounted for and the computerised system aided the stock control of medicines in the home. These processes helped to ensure that medicine errors were minimised,

and that people received their medicines safely and at the right time. We observed one senior member of staff administering medicines at lunchtime and they demonstrated safe practices.

Good

# Is the service effective?

## Our findings

People told us that they thought that staff had the skills required to care for them. One person said, "They do a good job." Another person told us, "They are really very good." Responses from the most recent relatives satisfaction survey were all positive when asked about the staff working in the service. It was clear from our observations of staff interacting with people that they knew and understood their needs.

Staff told us that there was a training programme in place which gave them the skills they required for their roles and had completed an effective induction programme when they had commenced work. One member of staff told us, "I've never done this work before and the training has been really good." Another member of staff told us, "The training has supplemented what I know already." One senior member of staff told us how they had recently undertaken a refresher course in medicines and then the manager had observed a medicines round to complete a competency check. They said, "It was a good course and held face to face. I then got to come back to the home for an observation and demonstrate my practice." Staff explained the variety of training courses they attended, both face to face and online, and were positive about how this supported them in their work. This was supported by the records we checked.

Staff also told us that they felt supported in their roles and received supervision, formally and informally on a regular basis. One member of staff told us, "I haven't had a formal supervision with the new manager yet but before, we always used the sessions to discuss anything we needed to." Another member of staff told us, "Supervision is open, we can talk about anything really." The staff we spoke with confirmed that they had received an appraisal. Records showed that staff received regular supervisions and that annual appraisals had taken place or were planned in line with when due.

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.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the MCA and the associated DoLs and we saw evidence that these were followed in the delivery of care. Where it had been assessed that people lacked capacity we saw that best interest decisions had been made on behalf of people following meetings with relatives and health professionals and were documented within their care plans. Authorisations of deprivation of liberty were in place for people who lived at the service as they could not leave unaccompanied and were under continuous supervision.

People told us that staff sought their consent. One person told us, "They ask me if they can help me before they start with anything." Another person told us, "Yes, they do ask me before helping me." Members of staff told us that they always asked for people's permission before providing them with care. One member of staff told us, "I always offer to help people and wait for them to answer. We can't just do things for people without asking and them agreeing." Another member of staff told us, "I always ask for people's permission and offer them choices." Our observations confirmed that staff obtained people's consent before assisting them with personal care or supporting them to transfer. Where people refused, we saw that their decisions were respected.

People were complimentary about the meals that were provided at the service. One person told us, "The food is quite nice; we get a choice of what we have. There is enough of it." Another person told us, "I get enough to eat and drink." There was a four weekly menu programme in place which had recently been changed to reflect the change in season and discussion at residents meetings. The menu we viewed offered people a variety of meals, in line with their dietary preferences. We observed the lunchtime meal and found that the meal time was relaxed. Where people required specific equipment or assistance to eat their meals we saw that this was provided and in a way that enhanced the mealtime for the person. We observed staff encouraging people to eat at their own pace and chatting with people in a relaxed manner.

We spoke with the cook who told us that all food was prepared at the service and people were given at least two choices for each of the meals with snacks available throughout the day. People had been asked for their likes and dislikes in respect of food and drink prior to moving to the service and their preferences. People were able to select alternative meals to those planned on the menu in advance, either on a regular or adhoc basis. Members of kitchen staff were notified of people's dietary requirements and were informed of any changes. Records held in the kitchen detailed people's preferences and specific dietary needs such as allergies, consistency requirements for example, a soft or pureed diet and any foods that people needed to avoid due to possible negative reactions to their prescribed medicines. There was no-one living at the service at the time of our inspection that required a special diet for cultural or religious reasons but the cook confirmed that cultural diet choices could be catered for. Members of care staff were aware of people's dietary needs and this information was documented in the care plans and risk assessments.

Members of staff told us that people were assisted to access other healthcare services to maintain their health and well-being, if needed. One member of staff said, "As I've worked here for a while now you get to know people and can recognise when there is something not quite right. The community matron comes on a Tuesday and will come other days if we are concerned about someone or we request the doctor." Records confirmed that people had been seen by a variety of healthcare professionals including the GP and district nurse. Referrals had also been made to other professionals, such as dietitians, speech and language therapists and physiotherapists.

Good

# Is the service caring?

## Our findings

People were positive about the staff and the care they received. One person told us, "They are very good, all nice and kind to me." Another person said, "Yes, it's alright, quite nice." A third person told us, "I'm ok, it's alright. I'd rather be at home but if I have to be somewhere, then it's alright. I can't grumble." The most recent satisfaction survey showed positive responses were received when people were asked if they were happy with the staff and how they were cared for.

People's bedrooms were personalised and had been furnished and decorated in the way they liked. Many people had brought their own furniture, pictures and decorations with them when they came to live at the service. The manager told us, "It's good for people to have familiar items; it makes their room a safe zone." They went on to explain how people were supported to feel more comfortable in their surroundings by having personal items and memorabilia around them and this enhanced their stay in the service. We saw pictorial images around the service and on doors to denote what each room was for. There were numerous areas throughout the service where people could go to spend time quietly or have privacy to meet with their family members if they wished. We saw that there was also an area for people to use a computer with an accessible keyboard and mouse to use Skype or email to make contact with friends or relatives. A further area had been identified as a suitable space for a sensory area where staff could support people to go if they needed to relax during a period of anxiety or agitation. Plans had been developed for this to be put in place in the future.

We observed positive interactions between staff and people that lived the service and found this to be friendly and respectful. We observed members of staff using each person's preferred name, taking the time to answer people's questions and promptly responding to requests for assistance.

Staff knew people well and understood their preferences. The detailed information in the care plans enabled staff to understand how to care for people in their preferred way and to ensure their needs were met. People we observed appeared comfortable and relaxed in the company of staff and staff engaged people in friendly conversation. We observed people laughing and joking in conversations with staff throughout the day.

The promotion of people's privacy and dignity was observed throughout the day. Staff members were able to describe ways in which people's dignity was preserved such as knocking on doors before entering, making sure they offered assistance with personal care to people in a discreet manner and ensuring that doors were closed when providing personal care in bathrooms or in people's bedrooms. The manager had recently purchased 'do not disturb' signs for use on the bathrooms and toilet doors to further enhance people's privacy. Staff all clearly explained that information held about the people who lived at the service was confidential and would not be discussed outside of the service.

We spoke with the manager about the availability of advocacy services and found that the service had previously used an advocacy service for people. We saw that information was available on how to access the services of an advocate should this be required.

There were a number of information posters displayed within the entrance hallway which included information about the service, safeguarding, the complaints procedure, fire safety notices, local community events and the activities available to people. We also saw the monthly newsletter compiled for people and their relatives and information from charitable organisations who provide services to older people and people living with dementia.

Good

# Is the service responsive?

## Our findings

When we inspected the service in May 2014 we found a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found inaccuracies within some people's care records and that some records were not fully completed. We asked the provider to take action to make improvements to the completion and accuracy of people's care records, and this action has been completed. People's care records had regularly been reviewed and were reflective of people's current needs. We also found that daily records were consistently completed and there were no gaps in the information that was recorded.

People told us that they felt involved in deciding what care they were to receive and how this was to be given. One person told us, "I do feel involved in things that happen. They ask me what I want to do, so yes I would say that I am included in my care." Records showed that pre-admission assessments were undertaken to establish whether the service could provide the care people needed. The computerised care plans followed a standard template which included information on their personal background, their individual preferences along with their interests. Each was individualised to reflect people's needs and included clear instructions for staff on how best to support people. We found that the care plan reflected people's individual needs and had been updated regularly with changes as they occurred. The operations manager and manager spoke with us in respect of new software that would be in place in the coming months which would enable staff to maintain more robust care records.

People's likes, dislikes and preferences of how care was to be carried out were assessed at the time of admission and reviewed on a regular basis. One person told us, "I have choices about things." Each care file included individuals care plans for areas of the person's life including personal hygiene, mobility, nutrition, communication and pressure care. People's care plans were reviewed regularly which ensured their choices and views were recorded and remained relevant. We saw that people and their relatives were involved in meetings to review the care provided. Staff that we spoke with demonstrated a good knowledge of what was important to people who lived at the service and this enabled them to provide care in a way that was appropriate to the person.

Activities were provided by the care staff on duty. Members of staff we spoke with were able to describe the different activities that people enjoyed, for example, listening to music, playing games and completing jigsaw puzzles but explained difficulties they had in engaging some people with meaningful activities. This had been discussed at a recent team meeting and activity training had been added to the service training plan. Photographs of recent events held at the service were displayed in the dining room and in one of the communal lounges. There was an activity schedule available in the entrance hall so people and their relatives knew the activities that were on offer or any future events that were planned. During our inspection we saw items that could be used to enhance people's stimulation, for example, a large doll and a small dog which appeared as though it was breathing.

There was an up to date complaints policy in place and leaflets containing the complaints procedure available in the entrance hallway. People we spoke with were aware of the complaints procedure and who

they could raise concerns with. One person we spoke to told us, "I would speak to [manager] if I had any problems." They went on to say they would feel comfortable complaining if they needed to. Formal complaints that had been received in the past year were recorded. There was a detailed investigation into each concern and the actions to be taken in response included. Each complainant had received a response to their concern and the operations manager had recorded the outcome from each.

Requires Improvement

# Is the service well-led?

## Our findings

The manager registered by the Care Quality Commission is no longer employed by the service but has not cancelled their registration. A new manager has been appointed and had been in post for two months. They intended on completing their registration. The manager was supported by a head of care and the operations manager from the provider organisation.

We noted that there was a relaxed, comfortable atmosphere within the service. People knew who the manager was and confirmed that they were visible in the service. One person told us, "I have seen the new man in charge here." A member of staff told us, "[Manager] has settled in well and has worked hard to get to know us and support us. I feel I can go to him with anything." Another member of staff told us, "I wouldn't want to work anywhere else." They went on to explain how the support of the management team had a positive impact on their work and how they enjoyed working at the service. During our inspection we saw that the manager and operations manager spoke with people and staff to find out how they were and were actively involved in the running of the service, the support and wellbeing of people living in the service and the experiences of the staff on duty.

Staff told us that there was a very open culture and they would be supported by the management team. One member of staff told us, "I feel happy to speak to either [manager] or [operations manager]. They always listen to us if we have anything that we need to tell them about, good or bad." Another member of staff told us, "All the seniors and the manager have been really supportive since I've started work here. It's been good." Staff were aware of their roles and responsibilities and were clear on the lines of accountability within the staff structure. They told us that the new manager had consulted with them prior to making changes in the service and that they felt involved in decision making. However, the members of staff we spoke with were not clear on the direction of the service or the overall service development.

We found that there were a range of audits and systems in place by the provider organisation to monitor the quality of the service provided. These included reviews of care plans, medicines audits, falls audit, incident and accident audit and complaints management. However, it was not always clear how any issues found in some of these audits would be addressed by the manager and where improvements required were recorded. The manager had begun to collate information from the audits they had completed and from their observations since starting to manage the service but had not yet recorded the actions that they planned on taking.

The manager showed us satisfaction survey forms that had recently been sent to relatives of people who lived at the service and members of staff. All of the responses seen were positive. The results had not yet been compiled into an action plan or responses drafted but we saw from previous surveys that this had been completed and the manager confirmed that this would be done.

Staff were encouraged to attend team meetings at which they could discuss ways in which the service could be improved and raise any concerns directly with management. Recent discussions had included activities, training, rotas, cleaning, menus and confidentiality. Members of staff we spoke with confirmed that they

were given the opportunity to request topics for discussion.

We noted that records were stored securely within the computerised system or within the manager's office. This meant that confidential records about people and members of staff could only be accessed by those authorised to do so.