Whitehall Care Limited

# Whitehall Lodge Residential Home

## Inspection report

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Date of inspection visit:
31 August 2016
01 September 2016

Date of publication:
10 October 2016

## 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? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on the 30 and 31 August 2016 and was unannounced.

Whitehall Lodge provides care for up to 25 people. The home supports older people with physical and mental health needs. The accommodation comprised of four interconnected Victorian terraced properties.

The registered manager had left the service a few days before the inspection took place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager was managing the home until the provider finds a replacement.

People's medicines were not always administered and stored in a safe way. Sometimes people did not receive their medicines as the prescriber had intended. Staff did not always check people had received their medicines. Staff did not always follow the guidance of the service in administering people's medicines.

People were not always kept safe as electrical products were not tested yearly to ensure they were safe to use. Equipment used to support people to mobilise was not always tested, to ensure it was safe to use.

The management team and the provider did not have effective systems to test the quality of the service provided.

These issues all contributed to breaches in the health and social care act.

The service was not responding to people's social needs who lived at the service. There was a lack of social stimulation for many people at the service. The service had not considered ways to engage with people and seek their views on the service.

We gave a recommendation about improving activities.

People benefited from being supported by staff who were safely recruited, trained and who felt supported in their work by their colleagues and by the deputy manager. Staff received yearly appraisals. Staff also had regular supervisions. There was enough staff to safely meet people's care needs.

Staff understood how to protect people from the risk of abuse and knew the procedure for reporting any concerns. Staff knew and understood the health and care needs of people who lived at Whitehall Lodge.

Staff told us they were happy and proud to work at Whitehall Lodge. They assisted people with kindness . People's dignity and privacy was maintained and respected. People were treated as individuals.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The service was depriving some people of their liberty in order to provide necessary care and to keep them safe. The service had made applications for authorisation to the local authority DoLS team and was working within the principles of the MCA.

People's care plans contained important, relevant and detailed information to assist staff in meeting people's individual needs. People were involved in the care they received. People's needs had been reviewed. People's care was person centred.

People were supported to maintain good health and wellbeing. The management team reacted proactively to changes in people's health needs.

The service encouraged people to maintain relationships with people who were important to them. People's relatives and friends were welcomed to the service and encouraged to visit.

There was a positive culture and a friendly atmosphere at Whitehall Lodge. The service felt welcoming and homely.

We found a breaches in Regulation 12 Safe Care and Treatment (2) (d) (e) and (g). We also found breaches in Regulation 17 Good Governance (2) (a) (b) and (e).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.

Medicines were not always administered and stored in a safe way.

The service did not take actions to ensure the safety of the premises and equipment used.

People were supported by staff who knew how to prevent, identify and report abuse.

### Is the service effective?

**Good**

The service was effective.

People benefited from being supported by trained staff who felt supported in their roles.

Staff assisted people in a way that protected their human rights. The service was meeting its responsibilities under the MCA.

The service ensured people received food and drink of their choice. People had enough to eat and drink.

People's health and wellbeing were supported and maintained by having access to appropriate professional healthcare services.

### Is the service caring?

**Good**

The service was caring.

Staff had a good knowledge of the people they supported and delivered care in a respectful and caring manner.

Care and support was provided by staff in a way that maintained people's dignity and independence.

People were involved in making decisions around the care and support they needed.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Most people did not experience regular social stimulation and social activities. People's cultural needs were not always met.

The service encouraged people to maintain meaningful relationships with those close to them.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

There was a lack of auditing systems in place to ensure a good quality service was delivered. The audits which did exist were sometimes ineffective.

The provider had no overall robust systems to monitor the quality of the service provided.

The service did not have systems in place to regularly gain people's views on the service provided.

The staff and the people they supported benefitted from a deputy manager that demonstrated dedication to the service.

People were supported by staff that were happy in their work and felt valued.

# Whitehall Lodge 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.

This inspection took place on 30 and 31 August 2016 and was unannounced. The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before we carried out the inspection we reviewed the information we hold about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

During our inspection we spoke with six people who used the service. Observations were made throughout the inspection. We also spoke with four relatives and a visiting health professional.

We spoke with the deputy manager and five members of the care staff. We also contacted the local safeguarding team, the local authority quality assurance team, and the clinical commissioning team (health) for their views on the service.

We reviewed the care records of three people and the medicines records of five people. We also looked at records relating to the management of the service. These included training records, health and safety check records, audits, accidents and incidents.

Requires Improvement

# Is the service safe?

## Our findings

We found that the service did not always ensure that people's medicines were administered in a safe way. On the day of our visit we observed people being given their medicines. During this process a member of the care staff went to sign the Medication Administration Record (MAR) chart, that a person did not want their 'as required' medicine. We asked why they hadn't asked the person, they said, "They never want this tablet anyway." This was not the correct procedure and it did not give people choice when administering people's 'as required' medicines. Some staff had also signed to say a person had been given their medicine, when they did not know if the person had received them.

During our inspection we completed an audit of the medicines stored in the medicines room. We found two tablets on the floor of the medicine cabinet. We showed this to the deputy manager who said, "Sometimes the tablets fall out of the containers." We were unable to identify who's medicines these were. The deputy manager said they would complete a full audit as soon as possible.

Although the temperature of the medicines room was being recorded no action had been taken when it was recorded as being above the recommended limit. This meant that the provider could not be assured that medicines that needed to be stored at a certain temperature would remain effective.

One person was at risk of choking and therefore had received specialist health advice. We looked at this person's record; we saw the advice regarding the dose of a certain medicine to prevent choking had changed. We observed lunch and saw a member of staff had given the incorrect dosage. This was because the MAR chart had not been updated and this information had not been shared with all the care staff.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited the breakfast room when we arrived and found some people eating their breakfasts, there was no staff present. One of these people was at risk of choking. The advice from a specialist health team was that this person should have staff present when eating, in order to take action if they started to choke. This meant the risks to this person were not effectively managed at this time.

The service had two stair lifts which were not being serviced on a yearly basis. The deputy manager was not able to find evidence of regular servicing or an upcoming service. We were told by the deputy manager that people used the stair lifts. We also found that all the electrical equipment should have been tested to ensure it was safe to use in May 2016, but this had not happened. We found the service was using fans in the communal areas and in people's bedrooms because of the summer heat, but none of these had been tested to ensure they were safe to use.

We could not find any evidence that the service was monitoring the water temperatures and testing for

Legionella. This is a bacteria which can grow in water supplies, and can cause people to become ill. We asked the deputy manager for the legionella risk assessment; they were unable to find it and did not know if it had taken place. We both concluded these safety checks had not taken place.

The above concerns also constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe, one person said, "I feel safe as I have confidence in the staff." Another person said, "I feel safe because I know there's someone around to help me if I need support and they just simply cater for all my needs." A relative told us, "The home takes every precaution to keep my [relative] safe."

Staff told us how they would identify if a person was potentially experiencing harm or abuse. All the staff we spoke with said they would inform the deputy manager or a senior member of the care staff. However, not all members of staff knew of external agencies such as the local authority safeguarding team, they could also contact.

We looked at people's records and we found the service had completed risk assessments of people's needs in order to manage these needs. People had a detailed assessment when they moved to the service and had regular reviews. We could also see when people's needs changed a new risk assessment would be completed to reflect this change in need. Referrals were made to health professionals if this was needed.

The service was proactive in supporting people who had health needs which were complex. We could see the service was following the advice from health professionals in terms of monitoring and preventing people's skin to break down, monitoring weight loss, and people's fluid and food intake. We found records confirming this was happening. When we spoke with the deputy manager we found they had a good knowledge of these people's needs and what the service needed to do in order to manage these risks and keep these people safe.

The service was recording accidents and incidents which people who lived at the service experienced. We looked at these records and we could see when a pattern emerged the service made contact with the GP. As a result of this we could see the GP made referrals to specialist teams in order to try and prevent these incidents from happening again. A number of people had received specialist involvement to reduce these incidents. We could see the service then worked with these particular health teams to reduce these risks.

The service regularly tested their fire equipment and there were monthly fire drills which involved care staff. There was an evacuation plan for the service, although people did not have individual personal evacuation plans. There were various contact details in the manager's office of various utility and maintenance professionals to contact if there was an emergency. However, there was no business contingency plan in place to support the service to continue running in the event of an emergency.

People told us there was enough staff at the service to keep them safe. One person said, "I don't wait long for them to answer the bell." Another person said, "I fell over and bumped into a table. Immediately three staff came over."

The deputy manager told us how they managed leave and sickness to ensure there was enough staff. The deputy manager also explained to us the rationale for the number of staff on shift.On the day of our visit we observed call bells were answered swiftly. Staff told us that they felt there were sufficient numbers of staff to keep people safe and respond to people's care needs.

We were unable to access the staff recruitment files. However, staff told us that the Disclosure and Barring Service (DBS) checks had been carried out by the service. The deputy manager told us that staff had updated DBS checks every five years.

Good

# Is the service effective?

## Our findings

People told us they felt staff were capable and competent in their roles. One person said, "I consider all carers to be well trained as they support me so well." Another person told us, "The carers all know what they are doing." A relative also told us, "The carers are very skilled."

We looked at the staff training records. We could see staff had received training in mental capacity, fire awareness, infection control, health and safety, moving and handling and safeguarding. We found that some staff had not received updated training in these areas. However, when we spoke with staff and observed their practice, especially when supporting people to mobilise and transfer from a sitting position, staff demonstrated a good knowledge in most of these areas.

Most of the staff had worked at the service for a long time. However, we spoke with newly employed staff who told us their induction had prepared them for the job. New members of staff told us they spent time shadowing experienced staff and, "Getting to know residents," for a period of three weeks. During this time new staff would begin to work independently. New staff were provided with face to face training days which included, safeguarding, mental health, health and safety and first aid. New staff spoke positively about the registered manager and the deputy manager. New staff also felt supported by their colleagues. One new member of staff told us the provider had approached them and asked if they needed further support to prepare for their new role.

One member of staff told us, "Staff know people really well, there is good communication." We were shown records confirming and staff told us, they received regular supervisions and appraisals. Care staff said they felt confident in speaking with senior care staff and the deputy manager. We observed care staff communicating effectively with one another throughout our visit.

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 so that they can 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. We were told about a person who had been deprived of their liberty to ensure they were safe. We could see the appropriate processes had been followed.

On the day of our visit we observed people moving freely about the service. One person had gone out to go shopping and others told us they chose to spend time in their rooms. Some people also told us they chose

when they went to bed and when they got up in the morning. The deputy manager said, "We just ask people to tell us, when they are going out, so we know that they have."

The deputy manager and the staff we spoke with demonstrated a good knowledge of the Mental Capacity Act and DoLS. Staff told us how they encouraged choice and sought people's consent when supporting them. One person told us, "They always ask permission before they do anything for me."

People spoke positively about the meals and drinks at Whitehall Lodge. One person said, "The food is good and so are the servings. I always like what they offer." Another person told us, "The food is very good. There's plenty of it, maybe too much."

We observed lunch and we could see people were given a variety of options. In the morning we saw a member of the care staff asking people what they wanted to eat. Staff asked people if they were happy with the food. Some people were offered alternative meals if they had not eaten much or changed their minds. People were asked what drinks they wanted. One member of staff said to people, "Its warm today, so have plenty to drink." Later in the afternoon a tea trolley with homemade cakes and sandwiches were offered to people, and some people chose to have something hot instead.

During lunch we observed staff supporting people to eat and drink. Staff directly assisted some people to eat and drink. We saw staff monitoring people while they ate their lunch and offer support if they looked like they were physically struggling to eat their meal. We saw a member of staff offering more gravy at lunch time, the member of staff offered the gravy dish to the person to pour themselves. Later at lunch time a member of staff said, "Let's cut this up together."

We spoke with the temporary chef who told us, "Everything is cooked from scratch…on the aga." During our visit we could see a variety of savoury and sweet baking was taking place. The temporary chef said the service had returned to purely cooking everything at the service. "I made my own fish and chips with a thin batter last week; it went down like a storm."

The people we spoke to confirmed they had involvement from health professionals when they needed to. Some people told us the registered manager used to take them to hospital. A relative told us, "They're on the ball when getting the GP in."

The service had regular contact with the GP surgery. The GP visited weekly and confirmed they spoke with the home at other times. The GP told us that the service always responded positively to changes in people's health needs and referred people appropriately. We could see from people's records the service had contact with various health and social care professionals, to update them and discuss their concerns. We observed the deputy manager updating a specialist health professional about a person's needs. The information given was very detailed.

Good

# Is the service caring?

## Our findings

The people we spoke with told us the service was caring and they enjoyed living at Whitehall Lodge. One person said "Carers are so good at looking after you. It's like a glorified hotel. We joke together." Another person said, "I am a person to them rather just part of their work. That's a good feeling." A relative told us, "Despite my [relative's] struggles and occasional awkwardness they still treat [relative] as a real person with patience, and every day is a new day."

The staff we spoke with told us they formed close and caring relationships with the people they supported. Staff were able to tell us about many of the people they supported, their backgrounds and what was important to them. The people who lived at the service and most staff told us they had formed friendly relationships with one another. A member of staff told us, "When I started, that's what really struck me, staff really know people." One person told us, "I feel content here because the staff treat me really well, it feels like a family here." The services' GP who visited the home weekly told us, "Staff know residents well and they are really caring towards them…Residents tell me they are happy."

Staff told us they brought a small gift for people (who they directly supported through the 'key worker' scheme) when it was their birthdays. A person told us, "I got flowers from the management on my birthday. That was a cheery moment." There were photos in the communal lounge showing people holding a birthday cake the chef had made. In the kitchen the chef had a list of people's birthday dates. The chef said, "I'll make a nice sponge cake for [Name] with lots of icing, it's no bother."

The staff we spoke with had a good understanding of equality and diversity. Staff told us it is about treating people as equals. We spoke with the deputy manager who told us how the service challenged people's prejudices within the home. The manager gave us examples of how the service supported people's diverse needs. One person told us, "They treat me as a person. They don't judge you. No matter who you are or your background, they treat you the same. If I had different beliefs or ideas to everyone else they wouldn't judge me."

Some people told us they felt involved in the decisions around their care. One person said, "I discussed my care plan with a member of staff." Another person told us, "I have a key worker who helps with the care plan."

When we visited the service we found all confidential information was stored securely. People told us that staff treated information about them in a private way. One person said, "They never talk about other residents in front of me." We observed handover took place in a closed room away from the communal area.

People told us they were treated with respect. One person told us, "They have absolute respect for me. They never force me, rush me or make me feel a nuisance at any time." Another person told us, "I am definitely treated with respect."

The staff we spoke with told us how they supported people with dignity and respect. Staff told us how they supported people at their own pace and followed people's preferred individual morning and evening routines. Staff told us they spoke to people throughout the process of supporting them, so people knew what was happening. We observed staff speaking with people in a respectful way. We observed mainly positive practice; however, we observed one example where we felt one person was not treated in a caring way. We discussed this with the deputy manager who said they would address this issue with staff.

People also told us how staff promoted their independence. People gave examples of completing daily tasks themselves and leaving the home when they chose to. One person told us, "I got involved in the Home fete, running a stall. I appreciate that." Another person said, "I was in hospital for some time before I came here and this place got me working by encouraging me. I was so ill but I put my improvement down to them."

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive to people's social needs. People told us they felt bored at times. One person said, "I do get bored because there's nothing to do. I watch TV but don't really like bingo." Another person said, "Only two of us want to play bingo, so that's not going to work is it? Everyone else just goes to sleep. I keep my mind occupied or I'll go the same way… then what's the point?" A further person told us, "I read my books and watch some TV but yes I do get bored, but I haven't told anyone because I don't want to stir things up."

Some people told us that the service supported their personal preferences. One person said, "I get up and go to bed when I like. I like eating in the dining room and I can go out of the home when I wish." A relative told us, "[Relative] lies in bed until [they] are ready to get up.

On the day of our visit we noted some people were able to go out into the city or the local area. People who were more independent with their daily needs tended to spend most of their time in their rooms, engaged in activities they enjoyed. These people spoke positively about their level of social stimulation and how much control they had with their daily life.

However, most people spent their day and early evening in the lounge. Most of these people were unable to communicate fully with us. We observed that most of these people either slept throughout the day time, or they watched staff and other people as they moved about the room. The TV was on but the television couldn't be seen from all areas of the room. We didn't observe staff chatting with people or see any attempts to engage people with activities and conversations.

There was an activities board with an 'activity' each afternoon but four members of staff told us this didn't always happen. We were told by more than one member of staff this was because people didn't want to do much. People were not encouraged to participate in activities. On the day of our visit staff began playing bingo with people in the communal lounge. However, people were not asked if they wanted to do this, some people found it difficult to participate. We heard one member of staff say to another, "Oh, it's nice to sit down for five minutes." We felt the service had not found a way to engage with these people and involve the home as a whole. One person told us, "I can have a joke with them but they don't have time to sit with me for a chat."

We recommend that the provider refers to current good practice about engaging people in meaningful activities.

We could see the service had a mini bus; this was used to take some people out on day trips. We were shown photos of these trips. Staff told us these trips had not happened for some time. One member of staff said, "People like going out." However, the service was not using the mini bus and taking people out.

During our visit we observed one person becoming increasingly distressed. This person was unable to fully

communicate with staff. There were times when members of staff stopped walking past and tried to engage with this person, there were also times staff walked past this person without speaking to them. On one occasion a member of staff spoke with the person, the person did not appear to understand what they had said and was still distressed, the member of staff left the person and began talking and laughing with another person who lived at the service.

We spoke with the deputy manager about this. They told us of historical attempts when the service and a specialist health team had tried to find ways to engage with this person and respond to their social and cultural needs. However, the service was not continuing with these methods and they were not trying to find new ways to meet this person's social and cultural needs.

People told us that the service welcomed their families and friends. One person said, "It's lovely because my family and friends can visit when they want." A relative told us, "The staff are lovely, just like friends. They greet me with a smile and a warm welcome."

We looked at people's care records and we could see these were person centred. These records contained detailed information about people's care needs. Their past experiences, their likes dislikes and what was important to them.

Requires Improvement

# Is the service well-led?

## Our findings

We found that some of the systems the management team used, to monitor and improve the quality of the service were not effective. The registered manager was completing some audits, which included people's care plans, and people's MAR charts, this also included an audit of the temperature of the medication store cupboard. However, these had failed to identify issues we found during the inspection.

We also found no evidence that the temperature of the water was being checked on a regular basis and the service was testing for Legionella. There was no system in place to ensure equipment was tested on a regular basis.

There were no systems in place to obtain the views of people who used the service. There were no regular meetings with people who lived at the service and their relatives. The last 'resident's meeting' was in November 2015. The service did not make regular attempts to gain the views of people who lived at the service. This meant that the management team did not know if people felt the service was meeting their needs. We found that people wanted more social stimulation, but the service was not aware of this.

There was no oversight by the provider regarding the service being delivered. The provider had no robust system of carrying out their own quality checks on the service to test the service was meeting people's care needs and they were safe.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a positive culture at the service. Some of the people who lived at Whitehall Lodge told us the service felt like a family home. One person said, "I feel content here because the staff treat me really well, it feels like a family here." Another person told us, "It's a jovial atmosphere which makes me happy to be here."

Staff told us they felt committed to the people who lived at the service and the service itself. Most staff had worked at the home for a long time. One member of staff told us, "I chose to work here because of the staff's philosophy of care." Another member of staff said, "I am proud to work here."

The deputy manager and the staff we spoke with all had a shared understanding of the values and identity of the service. Staff told us they strive to provide good quality care. Individual staff told us they aim to create, "A home from Home"; a 'homely' and 'welcoming feel' was often stated by staff. Staff told us they felt they could express their views about the service and raise issues with the deputy manager. Staff told us there were regular staff meetings and staff said they felt able to express their views at these meetings.

Staff were open about what they thought were the shortfalls of the service, the décor and look of the home. One member of staff said, "We're not the smartest of homes, but we are friendly, we care, we have big hearts

and we pull together."

The deputy manager and staff had recently tried to build relationships with the local community. They had a summer fete and invited people to attend in order to build links with their neighbouring area. However, the deputy manager did not have other plans to develop the service's relationship with the local area.

The registered manager understood their responsibilities and the information we hold about the service, told us they reported incidents to the CQC as required. Since the registered manager had left, the provider had told us interviews were taking place to replace the registered manager.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe care and treatment<br><br>The service had failed to protect people against risks by doing all that is practicable to mitigate any such risks.<br><br>Regulation 12 (2) (d) (e) and (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance<br><br>The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided.<br><br>Regulation 17 (2) (a) (b) and (e) |