Platinex Limited

Whitewaves Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Whitewaves Care Home is a residential care home which is registered to provide accommodation for up to19 older people, some of whom were living with dementia. The home provides accommodation over three floors with a passenger lift and stair lift available to access all floors. There was a total of seven care staff employed and the registered manager who provided support for people. On the day of our visit nine people lived at the home.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

People were not always safe. Risk assessment tools were in place but risk assessments were not updated when required to ensure people were protected from harm. Medicines were generally stored and administered safely. However the medicines policy did not meet standards specified in approved guidelines. People felt safe with the home's staff. Relatives had no concerns about the safety of people.

Thorough recruitment processes were in place to check newly appointed staff were suitable to work with people. Staffing numbers were maintained at a level to meet people's needs safely. People told us there were enough staff on duty and staff also confirmed this.

People told us the food was good. They were involved in planning meals and staff provided support to help ensure meals were balanced and encouraged healthy choices.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that people had not had capacity assessments undertaken and people were not protected in line with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff received training to help them meet people's needs. Staff received an induction and there was regular supervision including monitoring of staff performance. Staff were supported to develop their skills by means of additional training such as the National Vocational Qualification (NVQ) or care diplomas. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required.

People said they were well supported and relatives said staff were knowledgeable about their family member's care needs.

The registered manager told us people did not really enjoy planned formal activities such as bingo and games. She said people liked to chat and enjoyed activities that were spontaneous. However people told us

that they would enjoy the opportunity to get outside more and visit the local community

People's privacy and dignity were respected. Staff had a caring attitude towards people. We saw staff interacting with people but this was mainly to do with the care they were offering.

Each person had a care plan which provided information for staff to deliver support to people. However care plans did not reflect or record the needs and preferences of people. They did not ensure that people were consulted or involved in the planning of their care or in the reviews of their care and treatment

The registered manager operated an open door policy and welcomed feedback on any aspect of the service. There was a stable staff team who said that communication in the home was good and they always felt able to make suggestions. They confirmed management were open and approachable.

There were no records of any analysis of accidents and incidents so that opportunities to learn from incidents could take place.

There was a policy and procedure for quality assurance. However the processes undertaken had not identified the areas for improvement we found during our inspection. We found that there were not sufficient systems or processes embedded in practice to evidence good governance.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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.

Risk assessments tools were in place but risk assessments were not updated when required to ensure people were protected from harm.

Medicines were generally stored and administered safely. However the medicines policy did not meet standards specified in approved guidelines

People told us they felt safe. There were enough staff to support people and recruitment practices were robust.

Is the service effective?

Requires Improvement

Capacity assessment had not been undertaken which meant that people were not protected in line with the rquirements of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had access to health and social care professionals to make sure they received effective care and treatment.

People were provided with a choice of suitable and nutritious food and drink. Staff supported people to maintain a healthy diet.

Is the service caring?

Good

The service was generally caring.

People said they were treated well by staff. Relatives said the staff were caring and respectful in how they treated people. .

We observed care staff supporting people throughout our visit. We saw people's privacy was respected.

People and staff got on well together.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was task led and was not personalised. Care plans did not reflect the needs and preferences of people. They did not ensure that people were consulted or involved in planning their care or in the reviews of their care and treatment.

People were offered activities but these were not recorded. A number of people commented that they would like to be supported to go out more.

There was an effective complaints procedure which people, and their relatives, were aware of.

Is the service well-led?

Requires Improvement 

The registered manager had not notified CQC of events that affects the health, safety and welfare of people who use services in line with their conditions of registration.

There was a policy and procedure for quality assurance. However the processes undertaken had not identified the areas for improvement we found during our inspection.

Systems and processes were not always operated effectively to ensure good governance.

Whitewaves Care 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 checked 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 12 and 19 April 2016 and was unannounced, which meant the staff and provider did not know we would be visiting. Two inspectors carried out the inspection on the first day of the visit. The second day of the visit was carried out by one inspector.

Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we observed how staff interacted with people who used the service. We spent time in the lounge and dining room, as well as visiting people in their rooms. We looked at how people were supported in the communal areas of the home observing people's safety, care and activities throughout the day. We also looked at plans of care, risk assessments, and medicines records for three people. We looked at training and recruitment records for two members of staff. and also looked at a range of records relating to the management of the service such as complaints, records, quality audits and policies and procedures.

We spoke with five people and one relative to ask them their views of the service provided. We also spoke with the registered manager and two members of staff.

The last inspection was carried out in September 2015 where we made two recommendations to improve the service.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not managed appropriately or reviewed as needed. One person had sustained three falls between January and March 2016. Accident report forms had been completed which showed the person had suffered a minor cut to the cheek as the result of a fall on the first occasion on 1 January 2016. On 7 March 2016, the same person fell and sustained a wound to the scalp which required surgical intervention and an overnight stay in hospital. On 10 March 2016, this person had a further fall which resulted in a hip fracture and a week's stay in hospital to undergo an operation. Following the inspection, we raised a safeguarding alert to the local safeguarding authority for this person.

On the first day of our inspection we looked at this person's care record which showed that their care plan and risk assessments had not been reviewed or updated since January 2016. No action had been taken as a result of the first fall which may have increased their risk. The registered manager said that the risk assessment has not been updated as the fall was minor and it was not recognised that the person was at a greater risk. However the second fall resulted in further injury and hospitalisation without the risk assessment being updated prior to the third fall. In addition, whilst undergoing hospital treatment for the head wound, this person was identified as 'MRSA +ve' meaning that any infection caused by methicillin-resistant Staphylococcus aureus would be resistant to antibiotic treatment and could spread to others if not treated appropriately. A member of care staff described how they managed the person's wound through barrier nursing, however, there was no advice or guidance recorded within the person's care plan relating to the risk of infection being spread and steps to be taken by staff to prevent the risk of infection to others. On 7 March 2016, the daily record stated, 'His head is 'banded' up', then on 8 March 2016, it was noted, '[Named person] seemed a little agitated today. His bandage came off his head during the night. We covered his head with a bandage hat'.

We asked the member of staff, who was responsible for drawing up risk assessments, how often risks assessments were reviewed. They told us, "They were reviewed monthly", but that they were then advised, "We could change to risk reviewing every three months, so we review the care plan every three months". Whilst care records were reviewed every three months, risk assessments were not reviewed and updated as required which put people at risk of receiving inappropriate care. We spoke to the registered manager and senior carer about risk assessments who told us that although risk assessments were reviewed three monthly they would be reviewed sooner if required. On the second day of our visit we found that all risk assessments had been amended and they were now up to date.

Generally, people's medicines were managed so they received them safely. Medicines were ordered, stored, administered and disposed of appropriately. Only staff who had been suitably trained were permitted to administer medicines. We asked a member of staff whether anyone received their medicines covertly, that is, without their knowledge. Even though we were told no-one received their medicines in this way, the daily record of 18 March 2016 for one person stated, 'He tolerated his medication fine. Given on a spoon with some jam'. We drew this to the attention of the member of staff we questioned and they were unaware of this incident. The registered manager said that she had administered this medicine and that it was not covertly administered but was put on a spoon with some jam to make it easier for the person to take.

Medicines were stored in a separate secure and locked room. Medicines currently in use were stored in a medicines trolley that was housed in the medicines room. Whilst the temperature of the refrigerator was recorded when in use, the temperature of the room was not taken. This room contained no form of ventilation and could have posed a risk to the efficacy of the medicines stored within if temperatures fluctuated. The registered manager told us she would obtain a thermometer so that the temperature in the medicines room could be monitored. An annual pharmacy visit undertaken last year had identified some issues. For example, the provider's medication policy did not meet the standards specified in the latest National Institute for Health and Care Excellence (NICE) guidelines and that the policy had not been signed by staff who administered medicines to show they had read and understood it. At the time of our inspection several months later, these issues had not been addressed. The registered manager told us that she disagreed with the report provided by the pharmacy but had neglected to challenge the report. She said she would get in contact with the pharmacy to establish, what if any issues were outstanding.

The failure to assess the risks to the health and safety of service users and the failure to ensure the safe management of medicines is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to the management of any emergencies, for example, the outbreak of fire. A fire risk assessment was in place which had been reviewed in September 2015. The assessment recorded that all new staff would receive 'in-house' fire training on commencement of employment and refresher training would be arranged for existing staff every three months. Fire equipment and fire alarm systems had all been checked in January 2016 and were working safely. Where required, new fire extinguishers and equipment had been purchased. However, whilst an emergency evacuation sledge had been purchased to enable the safe evacuation of people from the first floor, there were no personal emergency evacuation plans in place that identified people's specific needs. We spoke to the registered manager and senior carer who told us that training was booked for staff to ensure they knew how to use the evacuation sledge and this training would include an evacuation exercise. WE RECOMMEND that the registered manager seeks advice and guidance from a reliable source to ensure that that emergency evacuation plans are put in place for all people including clear plans to enable people to be safely evacuated from the first and second floors when using the emergency evacuation sledge.

People felt safe at the home. They confirmed there were enough staff to provide support. All people who could express an opinion said they felt safe, were treated politely and with respect. Comments from people included, "I am quite happy". And "I am treated well and feel safe here". "One relative said, "I am happy with the way my relative is treated. I know he is kept safe".

The provider had an up to date copy of the West Sussex safeguarding procedures, which included guidance for the staff on how to deal with safeguarding issues. Staff understood their responsibilities in this area. Staff knew how to recognise the signs of potential abuse and what action to take if they suspected abuse was taking place. One member of staff said, "Safeguarding is to keep people safe from harm and abuse". They went on to explain what action they would take if they suspected someone was at risk and told us, "I would report it to the manager first of all and I'd expect something to be done immediately. If not, I would contact Social Services or CQC".

We spoke to the registered manager about safeguarding and she told us she would always report any concerns to the local safeguarding team. She explained to us that she had had declined to attend a recent safeguarding meeting with the West Sussex safeguarding team. She said that she had provided information to the team when it had been requested and that she did not have any additional information she could offer so did not see the need to attend the meeting.

The outside of the premises were untidy with building work part completed; although this was unsightly it did not present a risk to people. The registered manager told us previously that a new extension to the front of the property was being built. This extension of the property was being undertaken at our last visit to the service in September 2015. However work had not progressed and the extension remained at the same stage. Due to lack of progress the provider had closed access to half of the home until sufficient funds were available to complete the work. The registered manager was unable to tell us the timescales for work to be completed. This did not have any negative impact for people who lived at the home. During the inspection, we undertook a tour of the part of the home that was accessible to people. Accommodation was over three floors and there was a passenger lift and also a stair lift to provide access to the upper floors. We saw that people could move freely around the accessible part of the home. There were two lounges one of which included the dining area. The kitchen, office and laundry were situated on the ground floor, bedrooms were situated on all three floors and some of these were en-suite bathrooms and WCs were situated on the on the ground and first floor.

Recruitment records were seen for three staff and these contained all of the required information including two references, one of which was from their previous employer, an application form, an adult first check and Disclosure and Baring Service (DBS) checks. Adult first and DBS checks help employers make safer recruitment decisions and help prevent unsuitable potential staff from working with people. Staff did not start work at the home until all recruitment checks had been completed. We spoke with a member of staff who told us their recruitment had been thorough.

The home's staffing rota showed there were a minimum of two members of staff on duty at all times. The registered manager told us that she worked at the home every day and carried out care duties to assist. At night one member of staff was on duty and awake throughout the night, they were backed up by the registered manager who lived adjacent to the home who was on call to assist if required. The staffing rota for the previous two weeks confirmed these staffing levels were maintained. Observations showed that staff were not rushed and dealt with people's support needs in a calm manner. The provider currently employed seven members of staff plus the registered manager who worked every day in the home. Most of the staff had been employed at Whitewaves Care Home for a number of years so there was a consistent and stable staff group that were familiar to people.

We discussed staffing levels with the registered manager who said with the current occupancy level, there was sufficient staff on duty with the skills required to meet people's needs. Staff were expected to carry out cooking, cleaning and laundry duties as well as care tasks. Staff told us this did not present a problem as everyone worked as a team. They said there were enough staff on duty each day to meet people's needs. A relative said whenever they visited the home there were always enough staff on duty.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. We were told by staff that no-one living at the home was subject to Deprivation of Liberty Safeguards (DoLS). A request for a standard authorisation of DoLS had been completed for one person by the registered manager. One part of the form (A7) asks, 'The purpose for which the authorisation is requested'. The following information was recorded: '[Named person] does not have dementia; however, I feel she lacks capacity to make important decisions that would be in her best interests and in particular health. [Named person] has serious medical conditions that require continual monitoring and assessing on a daily basis'. This information related to this person's medical condition, dietary needs and medication and no assessments of capacity had been undertaken to provide the evidence required to conclude that this person lacked capacity. Also the reason for completing the DoLS for this person was not in relation to depriving them of their liberty.

Whilst there was no lock on the front door that prevented people from leaving the home, people told us that they were not allowed to go out unaccompanied. People said they were not allowed to go outside for a walk or into the front garden but were not sure why they were restricted in this way. Staff told us it would not be safe to allow people to go out independently. The registered manager said people would not be safe to go out on their own due to their dementia. She said people did not have capacity to make informed decisions regarding this. However there were no capacity assessments or best interests decisions recorded. This meant that people were being deprived of the liberty without lawful authority. We spoke to the registered manager about MCA and DoLS and she told us that she had started to send in DoLS applications to the local authority but had been informed that they should stop as the local authority were unable to process applications quickly due to the large number received.

The failure to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people plans of care and these contained information about peoples care needs. Staff were able to tell us about the people they cared for and they understood their needs.

Staff received training on a range of topics. Except for safeguarding training which had been delivered face to face by a trainer from the local authority, all training was delivered on line. Staff could borrow DVDs on specific subject areas and completed a range of multi-choice questions to demonstrate their understanding.

A member of staff who had completed a 'Train the Trainer' course would then look at the answers staff submitted and provide further support and guidance if required. The staff member responsible for training said she always observed staff practice after each training session to ensure staff had understood the training and were putting the knowledge learned into practice. We saw records of training observation carried out by the in house trainer and the registered manager. However the online training and monitoring for MCA and DoLs was not effective as the registered manager and staff lacked knowledge in this area.

We asked how often training was refreshed or renewed and were told this was, "As and when needed". Training sessions were recorded in a daily diary, but it was unclear which staff had completed which training. There was no system in place to monitor the training that staff had completed or when staff training needed to be updated. We spoke to the registered manager and senior carer who told us that training was recorded in staff files and with such a small staff team it was not difficult to just check staff files at regular intervals to check on training needs. Staff did not receive any specific training in end of life care, although one staff member said they had completed training in compassion awareness at a local hospice. The registered manager said that staff knew how to support people. She said she worked alongside staff and observed their practice and saw that they supported people with compassion and understanding.

A member of staff confirmed that they received supervisions with the registered manager every eight or nine weeks. Discussions were documented and signed off by staff and annual appraisals were also undertaken. In addition, the same member of staff confirmed that staff meetings were held monthly or six weekly and that minutes were taken. We looked at supervision records for staff and these showed that staff received supervision every six to eight weeks and that staff also received an annual appraisal.

People got on well with staff and told us the care they received met their needs. One person said, "It's very nice". " Another person said "I am quite content. Everything is fine". People were happy with the food provided and one person said "The food is good"." Another said "The food is home cooked, I always have enough to eat" People confirmed they could see the GP or nurse if they wanted to and one person said "They get the nurse out to see me quite often as I need my legs dressed".

Food was freshly cooked and looked inviting and people appeared to enjoy the choice on offer of either fish pie or sausage roll with vegetables. This was followed by profiteroles and cream or bananas and cream. Special diets were catered for, for example, one person's diabetes was managed through diet and another person had their food pureed, as recommended following their discharge from hospital. People told us they enjoyed the meals at the home and said the food was always good. One person said "Its proper home cooked food". The majority of people chose to eat in their armchairs, using over-chair tables. Only one person elected to sit at the table. All had places laid, with napkins and cutlery; most ate without assistance, but one or more care staff were always around to help if necessary, for example to cut food up, or assist with drinks.

We asked people if they had sufficient choice and they said if the main meal was not to their liking then they could always have something else such as omelettes, jacket potatoes, soup, salads or sandwiches and this was never a problem. The current system in place ensured people were provided with suitable and nutritious food and drink.

People's weights were monitored regularly, however, these were mostly estimated weights, rather than actual. A member of staff explained that weights could only be approximate as the majority of people at the home were unable to stand on weighing scales. However, no alternative scales, such as lift or chair scales, were available to provide a more accurate reading and monitoring of people's weights. We spoke to the registered manager about this who said that the cost of obtaining specialist scales was not cost effective.

We saw that one person's weight had been estimated which, according to the Malnutrition Universal Screening Tool (MUST), placed them above obese or severely overweight. Their weight had been estimated using the measurement of their upper arm as a way of calculation. However when we checked this with staff, we were told that this person ate a normal diet and was not severely overweight; this appeared to be the case when we saw this person later. There was no system in place to ensure that accurate information was gathered and recorded to ensure people appropriate action was taken to meet people's needs.

WE RECOMMED that the provider seeks advice and support from a reliable source so that people's weight can be monitored more effectively.

People were supported to maintain good health and had access to healthcare services or professionals. The care record for one person included their signed consent to receiving a 'flu injection and the district nurse had subsequently administered this. The same person's record showed they had received the services of a chiropodist who had visited at least every couple of months. However, care records had not always been updated for people since January 2016 to show the involvement of healthcare professionals. One person's daily records showed that a district nurse or GP had visited them on several occasions since January 2016, but their care plan had not been updated to reflect this

Good

Is the service caring?

Our findings

People were generally happy with the care and support they received. People told us they were well looked after and said the staff were kind and caring. Comments from people included, "X (named person) is very good, she will do anything for you". "The staff are very nice" and "I am treated well". One relative said the staff were always nice and friendly and got along well with their relative".

Staff cared for people in a kind and well-meant way and staff respected people's privacy and dignity. They spoke to people in a calm manner but we observed that conversations related to tasks, such as encouraging people to eat and drink, and were generally impersonal. Staff were not seen to talk with people apart from when they were offering support. This meant there was very little interaction that was not care related.

We observed one person was given black tea during the morning, without being asked beforehand what they wanted to drink. The care staff handed the tea to the person and said, "You have to drink it all". This was to improve the person's fluid intake but staff did not explain this to them. The person refused the tea and the member of staff then asked them if they would like coffee, to which the person agreed. The staff member brought the drink from the kitchen and said to the person, "Right, black coffee", then handed the drink over. We observed that drinks, including hot drinks, were given to people in open plastic beakers rather than in china mugs or cups and saucers. We observed staff supporting people to move around the home and they showed patience when people were mobilising using zimmer frames. They encouraged people but told them to take their time and that there was no rush.

We asked one person their views about the staff who cared for them and they thought staff were, "All right". However when one person was admitted to hospital recently, their relative, who was also living at the home, did not visit them during their stay and no arrangements were made to facilitate this or explanation given as to why this was not possible.

People were supported to maintain relationships with their families. Details of contact numbers and key dates such as birthdays for relatives and important people in each individual's life was kept in their care plan file. Two people had a relative who lived in Spain and the registered manager told us they kept in regular contact with them to keep them up to date with their relatives care and support needs. The relative confirmed this to us via email.

We saw compliment cards in the front entrance and they reflected on the support that had been given to their relatives. One card said, 'Thank you to all the staff at Whitewaves who have provided (named person) with wonderful care' and 'We can't thank you enough for the care you gave to (named person) please thank all your staff'.

People were confident to approach staff and any requests for support were responded to quickly and appropriately. Staff appeared to know each person well and always used their preferred form of address. We observed staff providing support in communal areas and they assisted people to be comfortable and encouraged people to keep mobile. Staff said they enjoyed supporting the people living in the home.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was passed verbally in private, at staff handovers. This helped to ensure only people who had a need to know were aware of people's personal information.

Requires Improvement

Is the service responsive?

Our findings

Some people did not know they had a care plan. Care plans we looked at provided no personal histories about people or information on their likes, dislikes or preferences. Whilst staff may have known people well, we observed no instances of personalised care or interaction between staff and people that demonstrated people were cared for in a person centred way. Care plans lacked information about people's choices and preferences. We asked people if they were involved in the planning of their care or if they were consulted in how their care was provided. No one we spoke with had been involved in the planning of their care.

Care plans seen were task orientated with information regarding the person's abilities, needs and aims of the care plan. We saw information in care plans relating to the delivery of people's care and there was information to staff about people's needs relating to areas such as dressing, communication, breathing, mobility, falls, moving and handling, skin integrity and pain management. However these were compiled with no input from people. One staff member told us that relatives and families were involved in planning people's care and were kept informed. They stated, "People stay in contact by 'phone". However, the majority of people did not have relatives in close contact. The staff member was asked whether people were involved in planning their own care and they said, "Mostly, it's the families. They said we do ask people if they are happy and if there is anything they would like changed". However they acknowledged few people had relatives involved. People we spoke with were content with the care and support they received. However they said they were not always consulted. There was no information in care plans about people's past history, such as what they did for a living, where they were brought up or what they liked doing. The lack of this information did not give staff any ideas for topics of discussion or any idea what people's interests may be.

One care plan stated the person was unable to manage their own skin care, unable to bend and attempt washing and needed full care. The care plan went on to instruct staff to ensure the person's legs were creamed at least once per day and to monitor on a regular basis. There was no information that this was carried out by staff. Daily records compiled by staff were only completed once a day. They did not provide evidence of care delivery. For example one person's daily record continually stated, 'Pad changed x 2 am', so it was not clear whether the person had their continence pads changed throughout the day and night or just twice every morning. Daily notes were only one or two lines and did not always provide information about the support people received throughout the day.

Staff were able to tell us about the people they cared for and they understood their needs. However people's preferences and choices for their end of life care were not always clearly recorded, communicated or kept under review. Care plans, in the main, provided scant detail about people's end of life care or wishes. We looked at the plan for one person who was being supported with end of life care. The registered manager told us she had contacted the National advice line on 111 for advice on the 10 April 2016 and was advised to keep the person hydrated, record, food and fluid intake and ensure the person was turned regularly to prevent pressure areas developing. The person's GP was then contacted on the 11 April 2016 who advised that they should continue with the care being provided. The registered manager stated that she had also been in contact with the person's next of kin, who we were told had power of attorney and they

had agreed with the care being provided. The registered manager said staff had been informed of the support the person needed but on the first day of our visit the care plan had not been written up. On the second day of our visit which was a week later, we saw that the person's care plan had been updated, there were food and fluid charts in the person's room where dietary intake was recorded, there was also a turning chart where the person's position in bed was recorded and their position was changed at regular intervals.

At the last inspection we discussed how care plans were reviewed with the registered manager. At this visit we saw some changes had been made but there was no evidence that people had been involved in their review. There was a three monthly review that provided some evaluation of how the care plan was working for the individual but no evidence who had been involved in the review. For example one person had three falls in January resulting in major changes to the person's care needs, however the care plan was not updated to reflect this as the three month period had not expired so no review had taken place.

Care plans did not always reflect the needs and preference of people. They did not ensure that people were consulted or involved in the reviews of their care and treatment. Nor did they ensure that people's nutritional and hydration needs, having regard to the service user's wellbeing were being met (refer to the 'Effective' section in this report). This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were kept up to date about people's well-being and about changes in their care needs by attending the handover held at the beginning of each shift. On coming staff were given a verbal handover by the staff coming off shift about any information they needed to be aware of. The registered manager had purchased a large diary where any handover information or important appointments could be recorded. Staff told us this was useful and helped them to keep up to date with people's needs. However when looked at, this diary only contained details of hospital or GP appointments; there was no handover information contained in the diary, such as if anyone needed extra support. We asked the registered manager about this and she told us that this information would be handed over verbally. She said she would remind staff to record important information in the diary so it was not forgotten.

We saw little opportunity for people to follow their interests or take part in social activities, unless friends or families visited or took people out. Overall, there was a lack of mental stimulation for people and our observations were that people had little social engagement with staff, which was mainly task led. A television in the lounge and another in the dining area remained switched on throughout the day, but people did not appear to be interested in watching. The majority of people were sat in armchairs in the lounge, dining or conservatory areas and were dozing or asleep. No organised activities were on offer, although one member of staff told us that they regularly had 'sing-alongs', Bingo and reminiscence sessions with people. On the day of our inspection, the weather was dry and quite warm, however, no-one was supported to go out into the garden. One person confirmed there was little to do and said, "I would like to do anything", including going out into the garden. They went on to say that they would like pictures to look at and chat about with staff and referred to photos on display in their room of the house where they used to live.

We asked people whether they found enough to occupy themselves and whether they ever felt bored. Most said 'no', but agreed that they would like the opportunity to try different things. One person we spoke with could not understand why they could not go out into the front garden to enjoy the afternoon sunshine or go for a walk. Staff told him 'it's not safe' but did not elaborate on this and explain the reasons why they could not go out. We spoke to staff about people going out and we were told, "I would have to run this past the manager, I am not sure she would like it as it would not be safe for them" We spoke with the registered manager who told us she was frustrated as she had tried numerous activities for people but they just did not

want to get involved. She said the one regular activity that people enjoyed was the 'Pat Dog' that visited every week; she said this was enjoyed by everyone. We looked in the activities file and saw that the activities recorded were sing alongs, Pat dog and Bingo. However the registered manger said they try other activities but they do not record these. There was no record that people had been offered activities but had declined.

WE RECOMMED that the provider speaks with people and relatives to establish what people's hobbies and interests are. This would assist the provider to establish what activities people did or did not enjoy. It would also give staff ideas on what activities to offer people that was meaningful and provided mental stimulation.

People and their representatives were asked for their views about their care and support on offer by means of a survey which is sent out each December. We looked at the survey from 2015 and this showed that 10 people responded to the survey with a 100% satisfaction return.

The provider had a clear complaint's procedure and this was displayed in the entrance hall to the home. The complaints record we looked at showed the last complaint recorded was in 2012. We asked the registered manager if she had any complaints from relatives who had raised concerns with social services and she assured us that they may well have spoken to social services but had not raised a formal complaint with the provider. We spoke with a relative who told us "I have never had to make a complaint, but if I did I am sure it would be quickly sorted out". The provider's complaints policy and procedure stated that complaints would be responded to within an appropriate timescale.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we discovered that two people had been admitted to hospital since our last inspection in September 2015. However the registered manager had not notified the Commission of these events. We spoke with the registered manager about these incidents who told us she was not aware of the need to report these to CQC.

The failure of the provider to notify the Care Quality Commission of events that affects the health, safety and welfare of people who use services is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked staff whether they thought the home was well managed and well led. One member of staff told us, "There's lots of discussion goes on here, there are no problems". They added, it was, "Very comfortable to work here. The residents come first and they seem okay. We all help each other and get on". There was a stable staff team, many of whom had worked at Whitewaves Care Home for a number of years. The registered manager was confident staff would talk with her if they had any concerns.

The registered manager said she aimed to ensure people were listened to and were treated fairly. The registered manager told us she operated an open door policy and welcomed feedback on any aspect of the service. She told us that she had not received any negative feedback from people, relatives or staff. People said they could talk with the registered manager and staff any time. One relative we spoke with confirmed the registered manager was approachable and said they could raise any issues with her or a member of staff.

At the last inspection in September 2015 the registered manager said she did not hold formal meetings for people or hold staff meetings as they were a very small team and she regularly saw people on an individual basis. We discussed that staff may be reluctant to speak up individually and a group meeting would provide a forum for people and staff to share their views. The registered manager agreed that regular meetings would be beneficial for people and staff and she said that changes would be made to facilitate this. At this visit we saw that the registered manager had introduced staff meetings and these were held every two months. We saw minutes of the last two staff meetings and these related to general issues about the home. However the minutes of each meeting did not start with a review of the previous minutes and therefore did not provide any evidence that actions agreed at previous meetings had been addressed.

Information leaflets were available in the entrance to the home about local help and advice groups, including advocacy services that people could use. These gave information about the services on offer and how to make contact. The registered manager told us they would support people to access an appropriate service if people wanted this support. There was a copy of the most recent inspection report and a suggestion box where people could raise issues. The registered manager told us that this was not well used and she could not remember what the last issue put forward in the suggestion box was or what it was about.

At the last inspection we asked the registered manager how learning took place from any accidents, incidents or complaints. She told us that any issues were discussed with staff verbally and if necessary changes were made. She acknowledged that on reflection this should be recorded so there was a reminder for staff on the potential consequences and to provide evidence those improvements had been made. At this inspection the registered manager acknowledged her intention to improve how learning from events was recorded and evidenced. However accidents and incidents were reported as individual events and records were kept in people's care records. There was no record of any analysis of accidents and incidents and a series of falls for one person had not resulted in any review to see if any lessons could be learnt. This meant that opportunities to learn from incidents could be missed and that could increase the chance of the same incident happening again.

We spoke with a representative from West Sussex social services commissioning department who told us that the registered manager had not attended any training courses that had been offered to her by the local authority. As a result of this comment we asked the registered manager how she ensured her own personal knowledge and skills were up to date. The registered manager told us that she had over 20 years' experience in providing care to people and said she undertook training provided at the home, however she agreed that she had not attended other training as she worked a number of hours at the home and could not always spare the time to attend courses offered.

The provider had a policy on quality assurance procedures to help the provider and registered manager ensure the service they provided was of a good standard. The registered manager told us she carried out audits which included medicines, food hygiene, health and safety, fire alarm system, fire evacuation procedures and care plan monitoring. However these audits had not identified the areas for improvement we found during the inspection.

Findings from this inspection demonstrated that the registered manager and provider had not acted upon known risks and shortfalls. Systems and processes had not been operated effectively to ensure the registered person's operated good governance. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. 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 provider failed to notify the Care Quality Commission of events that affects the health, safety and welfare of people who use services. Regulation 18(1)(2)(a)(i)(ii)(b)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people were consulted or involved in planning their care or in the reviews of their care and treatment. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)(e)(f)(g)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failure to act in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and keep up to date the risks to the health and safety of service users and failed to ensure the safe management of medicines. Regulation

12(1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate systems and processes effectively to ensure good governance. Regulation 17(1)(2)(a)(b)(f)