Medical Resources Worldwide Limited

The White House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
The White House Nursing Home provides accommodation, personal and nursing care to older people. The care home accommodates up to 67 people in a purpose-built building. At the time of the inspection 52 people were living there.

People's experience of using this service:
Since November 2014, The White House Nursing Home had been inspected seven times prior to this visit being carried out. Out of those previous inspection five of the seven were rated as requires improvement and one was rated as inadequate. Four of those inspections resulted in breaches of regulations. Six of the seven inspections found shortfalls in relation to the governance systems in the home. At this inspection, the eighth inspection in five years, we found that the governance systems remained poor and there were further breaches of Regulations.

Accidents and incidents were not reviewed to help identify themes and trends and it was not clear if all unexplained injuries were recorded, investigated and reported. This was because of the lack of monitoring of these issues. The acting manager showed us that recent unexplained injuries were being managed appropriately, however, we could not be sure this had happened prior to the most recent incident.

Not all staff had attended fire drills and the fire risk assessment had not been reviewed. There was no fire policy available on the day of inspection. Following the inspection this was received but the content was basic and did not clearly set out responsibilities.

People told us that their care needs were met. We found that for people less able to request support for themselves, there may be times when care was delayed. Relatives and staff told us that there were not always enough staff. People who were able to request support told us that there were enough staff most of the time. On the day of inspection, we saw people were still receiving morning care on the approach to lunchtime. Care plans did not reflect that this was people's choices. Although there had been staffing concerns, particularly at weekends, there were no management plans in place to ensure shifts were not left low in numbers when staff were absent.

Care plans were detailed and included enough information for staff to be able to support people for basic care needs. However, they did not include all elements of people's needs and some areas were not completed or accurate. For example, there were no plans to support people with any needs which were impacted by living with dementia or the behaviours that may challenge. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff knowledge and responses to the needs of those living with dementia needed further developing. For people who were calling out, there were no interventions or strategies to help alleviate people's anxiety or

behaviours. People gave mixed views about the activities available. People who were in their rooms were at risk of being isolated.

People told us that they received their medicines when needed. However, medicines were not always managed safely. People told us that they enjoyed the food.

There were systems in place to help ensure staff were trained and received regular supervision and staff felt supported by the management team. However, some staff was due to be refreshed and some subjects needed more advanced training, such as dementia awareness. The recruitment process was not always completed in a robust way so that they ensured that people were supported by staff who were suitable to work in a care setting.

The service met the characteristics for a rating of "Inadequate" in two key questions and the rating of "Requires Improvement" in three key questions.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection (and update):
The last rating for this service was requires improvement (7 August 2018). At this inspection the rating deteriorated, and the provider was in breach of some regulations.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
We have identified breaches in relation to governance systems and person-centred care at this inspection.
For requirement actions of enforcement which we are able to publish at the time of the report being published:
Please see the action we have told the provider to take at the end of this report.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led Details are in our Well led findings below.	**Inadequate**

The White House Nursing Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors.

Service and service type:
The White House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager who was applying to be registered, left employment the week prior to the inspection.

Notice of inspection:
The inspection was unannounced.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection:
We spoke with the deputy manager who was acting as manager, the newly appointed manager who starts in the role on 1st August, the providers, and 13 staff members. We spoke with seven people who used the service and six relatives about their experience of the care provided. We reviewed eight people's care records, medicines administration records and other records about the management of the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risk assessments for the use of oxygen needed to be more detailed to ensure staff were all aware of the risks associated with managing oxygen. Oxygen cylinders were stored safely and there was signage for the use of oxygen.
- Staff did not always work safely. We reviewed the records for one person who was assessed as being at risk of choking and required a fork mashable diet. On 7 July 2019 the person was recorded to have been given sandwiches for their evening meal. This placed the person at increased risk of choking. This issue had not been identified by the management team.
- Although a fire risk assessment had been carried out in 2017 and the actions identified had been signed as completed there had been no annual review to ensure that there had been no changes since the risk assessment was completed.
- Not all staff had attended fire drills and some staff needed to be prompted about what to do in the event of an emergency. A drill had been carried out in April 2019 which 14 staff attended. However, the remaining 60 plus staff had not attended a drill in the past 12 months. Staff had received training and more training was booked. We asked to review the fire policy, but the management team were unable to find it.
- Following the inspection, the acting manager sent us a fire policy dated the day of inspection. However, this did not include all expected elements, such as timings for fire drills. They also told us that they would be completing drills monthly to ensure all staff attended a drill in the next six months.
- Although accident and incident forms were added to people's electronic care plans the system collated the information into bar charts, it did not enable the management team to review the accidents and incidents for themes and trends. For example, where this had been completed in April 2019 on a paper format, is showed there were more falls between 2pm-8pm. As there was no facility to check this for May and June, we were unable to see if this was a theme due to staff being reduced in the afternoon, or just an increase during April.

Due to the lack management of health and safety issues, relating to the health, safety and welfare of people and others who may be at risk, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- People had their individual risks assessed and the assessments were clear in most cases.
- People's individual evacuation plans (PEEPS) were displayed in people's rooms and were clear.
- People who had bedrails in place had the protective bumpers on to help prevent them from injury and bedrail checks were in a place.

●Risk assessments were incorporated in care planning for risks such as pressure care management, falls and mobility. Staff told us each person had their own slings if they needed to be transferred with a hoist. This was detailed in plans.
● Repositioning charts were completed on the first floor however on the ground floor they were not always completed consistently. For example, where a person was assessed to require four hourly turns they were gaps in recording of up to six or seven hours and there was no record that staff changed their position. The acting manager told us for one person that they did not require repositioning and the care plan was incorrectly completed.
●People were assessed for the risk of developing pressure ulcers and where there was a risk identified pressure relieving equipment was in place to prevent this from happening. Mattresses were found to be set at the correct setting. Most people on the nursing unit needed staff assistance to mobilise, therefore there was a low number of falls recorded. People identified at risk of falls had sensor mats in place to alert staff if they needed help.

Systems and processes to safeguard people from the risk of abuse
● There was no monitoring system for unexplained bruises and skin tears. For a period up to April 2019 a log sheet was kept of injuries. However, this did not state if injuries were because of falls or if they were unexplained. The acting manager told us of the process they followed for an unexplained injury and this was appropriate. They also showed us a recent investigation they had completed, and the actions taken.
● However, for older injuries we were unable to track back to see how people suffered the noted bruises and skin tears as the electronic system did not go back to the dates listed. Therefore, we could not be sure that appropriate action had been taken. In addition, there remained no overview of these issues to help identify themes and trends.

Due to the lack of records indicating the appropriate action had been taken in relation to unexplained injuries, this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People told us they felt safe. One person said, "You press the buzzer and they come, with a smiley face."
● Safeguarding information displayed around the home and we saw staff were reminded about their responsibility to recognise and report any concerns relating to abuse.
●Staff working at the home had received training regarding safeguarding people from abuse Staff knew how to report any concerns they had within the home and we saw that staff reported concerns they had to the management team. They were reminded of their responsibility during staff meetings.

Staffing and recruitment
● People told us there were enough staff to meet their needs. One person said, "They come when I call them." However, relatives told us they felt there was not always enough staff. One relative said, "Sometimes [person] is not washed and dressed until almost 1pm." We reviewed this person's care notes and found that this was accurate.
● We were advised by the management team, staff and relatives that under the previous manager staff morale had decreased and this had resulted in staff leaving and calling in absent for shifts. Relatives and the management team told us that they had already seen a difference since the management changes had been made.
● Most staff said that staffing levels were too low. Staff said that people's dependency levels had increased significantly and that many more people needed assistance of two staff. They said every aspect of people's care needs had increased (eating, toileting, hoisting) which meant everything took longer resulting in personal care still being done at 11:30.

●People's dependency tools were not all completed. The acting manager told us they were a work in progress. However, as these had not been completed the management team did not know how many people of low, medium and high needs they had or how these would inform staff levels needed. The management team told us they based staffing on staff feedback. However, staff told us there were not enough staff.
●During the afternoon shift, on the ground floor, which supports people living with dementia, staff were reduced by one. The management team told us this was because it was not so busy in the afternoon. However, we noted that people's needs did not reduce in the afternoon and often for people living with dementia, during the afternoon and evening, this can be a more unsettled time for people. This had not been considered.
●There was not an effective system in place for monitoring staffing levels or determining what was needed. Accidents and incidents were not analysed for themes which may indicate issues with staff levels at peak times.
● Recruitment files included information to help the registered manager make good decisions about the staff they employed. However, they did not always include a photo of the staff member and references were not always verified. In addition, we saw that where a staff member had previously worked in a care setting, if this was not the last employment, or had not been added as a reference, the provider did not seek a reference from that care setting which would be good practice. We also found that employment gaps were not always fully explored to include dates.
● The recruitment process had a check sheet to ensure that the process was being followed. However, this had not identified the gaps found as part of the inspection.

Therefore, due to concerns around staffing levels and not adhering to a robust recruitment process, this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not always administered, stored and recorded safely. We counted a random sample of medicines and found that while most of the records and quantities were correct, one was not. The daily counting and recording systems had not identified this and records were wrong.
●We also noted that one box checked had extra tablets added to it rather than keeping tablets in separate boxes, so they agreed with their displacing labels. This is not best practice.
●The front profile sheet included relevant information to guide staff when administering medicines. However, we found one of those reviewed had another person's name typed into the text.
●The staff signature list needed to be updated to include all staff who were dispensing medicines.
● Regular checks and audits were completed. This included daily counts of boxed medicines.
●People received their medicines when they needed them, including time specific medicines.

Preventing and controlling infection
● The home was clean on the day of the inspection. The housekeeping staff were moving around the home and cleaning all areas. People and relatives told us that the home was kept clean.
● Staff had received training and were seen to use gloves and aprons in most cases.

Learning lessons when things go wrong
●We reviewed some staff meeting notes and found that they had discussed some areas of practice, such as outcomes of inspections. However, they had not addressed all the concerns we found during this inspection which demonstrated the management team had not identified the shortfalls.
● The provider had not used learning from previous inspections to ensure they complied with the standards.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained as requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us that they liked the food offered. One person said, "I had an omelette, it was nice and hot as cooked fresh." Another person told us, "They ask me what I want."

● Food choices were taken prior to the mealtime and the management team were working on developing pictures of meals to help people recognise meal choices. There were no menus on the tables. However, there was only one main meal choice and people needed to ask if they wanted an alternative, such as an omelette.

●When speaking with a staff member about people's modified foods they were able to speak about each person who needed their food and drink modified. Pureed food came from the kitchen with each food group separated to give people the different tastes and textures while eating. However, we observed that some staff mixed the pureed foods all together with no understanding of why the foods were separated.

● People living in the home had a range of dietary needs. Some people's cultural and religious beliefs influenced the type of diet they had, where other people needed modified or specialist diets due to their health needs.

● The kitchen staff spoken with understood dietary needs in the home and were kept informed of changes.

● People's care plans contained information about their dietary needs and some likes and dislikes. However, this was not always accurate. For example, one person was assisted to eat during lunch, but their care plan did not reflect that was an assessed need.

● Most people were supported in a calm and patient way when being assisted to eat. However, we observed one staff member go to assist someone in their room to eat. The person was lying flat and asleep. The staff member said morning and then went on to raise the head of the bed without warning the person. They then started to put spoonful's of food in their mouth, without telling them food was coming, and without the offer of a drink first to wet their mouth as they had just woken up. This was not only a risk to the person's safety as an increased choking risk, but also did not consider the person's experience. We noted the person did not eat all their breakfast, however, this was not recorded in the person's care plan.

● Food and fluid charts were completed for those assessed as being at risk of not eating or drinking enough. The electronic care plan system totalled the amount of fluid consumed. However, fluid targets were not set and there were gaps in meals recorded.

●Drinks were always available for people. We saw hydration stations around the home and staff assisting people to drink.

● Where people were at risk of losing weight, there were management plans in place to address this. There

was no overview of weights to help identify if everyone's weights were stable.

Supporting people to live healthier lives, access healthcare services and support
● People were supported to have access to outside professionals.
● A GP visited weekly and a list would be made of anybody wishing to see the doctor.
● A chiropodist, dentist, tissue viability nurse and optician all visited the home on a regular basis. The home was trying to find a visiting hairdresser at the time of inspection.
● We saw that all changes in health were documented.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● People's care plans were written in a way that reflected care was in their best interests and explained why care was needed. However, capacity assessments and best interest decisions had not been fully completed for everyone.
● Where specific care plans were written, it noted about the person's capacity relating to that decision. However, the formal process had not always been completed since the new care plan system had been implemented three months previously. The acting manager acknowledged that this wasn't completed, and they planned to get this completed as soon as possible.
●Staff received training relating to the MCA. However, the acting manager told us that they felt that not all staff fully understood the MCA 2005 and the processes needed. They had arranged for training with a local care provider's association which was planned for the upcoming weeks.
●DoLS applications were made when needed, authorisations had been granted for some.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff told us that people, and their relatives where appropriate, were sometimes involved in planning care. However, there were no signatures within the care plans to confirm the person or their representative had endorsed its content.
●During a recent resident and relative meeting, people were advised that they were able to log in online and review the care plan content. We discussed with the management team the need to ensure that any relative doing so had the appropriate authorisation to do so.
● People told us that staff asked them before support was given.

Adapting service, design, decoration to meet people's needs
●Some bedrooms were personalised, and people had their personal items around them. The home is designed in a way that people can move around easily whether independently or with the use of mobility aids. The home was clean and odour free.
● There was ample communal space which was decorated nicely, and we saw people using the main lounges and dining room.
● There was a pleasant garden area which people used.
● Development was needed to ensure the environment was more dementia friendly. For example, items around for people to find interesting or stimulate their sense.

Staff support: induction, training, skills and experience

● Staff were all happy with the training provided. They said this had increased over the past year. One staff member said, "We are asked if there is any further training we wish to have. Eight nurses went to the hospice for two-day end of life training. Last week we had a catheterisation refresh."

● Staff said they had regular one to one meetings with a line manager. They said they had advance warning of the supervision meetings, so they could prepare themselves.

●Records showed that training was ongoing, and most staff had attended all training. Some was now due to be refreshed and we saw that more training sessions were planned.

●However, in relation to dementia awareness training, 33 of the 82 staff listed had not attended this training and for those that had, many of them completed the training two or three years previously and no advanced courses were delivered, even though a high number of people living at the home were living with dementia. There was also no training for staff to enable them to support people with behaviour that may be challenging.

Staff working with other agencies to provide consistent, effective, timely care

● The home was being visited by the clinical commissioning group and the local authority to improve care for people. There was an action plan in place which the management team were working through. Some progress had been made, for example, the introduction of a care plan audit.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported

- People and their relatives told us that they felt the staff were kind and respectful. One person said, "Staff are all lovely." A relative told us, "They are all so good, they work so hard, they are starting to feel appreciated again now." The relative told us how the previous manager had a negative impact on staff.
- People's life histories, religion or cultural beliefs, hobbies and interests were recorded in people's care plans. However, we could not see how this influenced staff approach and improved people's lives. For example, some staff did not consider using this information to put on a TV programme that they may find enjoyable due to past interests.
- Most staff were attentive and stopped and chatted with people. We also heard some staff chatting with people while they supported them. However, due to the lack of engagement for people living with dementia this impacted on people's anxiety levels. As a result, people were calling out and staff did not respond as this was seen to be the norm. This impacted not only on people who were calling out, but also on those who were sharing the communal space.
- Staff appeared happy in their work which helped to make the atmosphere light.

Supporting people to express their views and be involved in making decisions about their care

- People told us that they felt involved in planning or reviewing their care. Relatives told us that they were involved.
- People told us they got to choose what care they received, and staff did not just assume what was needed. One person said, "They always ask me first." The care plan profile gave a summary of people's needs and choices.
- We heard staff asking people's choices throughout the inspection.

Respecting and promoting people's privacy, dignity and independence

- People were dressed appropriately in most cases. However, we saw one person in a state of undress while in bed when we arrived as their bedroom door was open.
- Staff knocked on doors before they entered.
- Throughout the day we observed bedroom doors open especially for people who were not able to communicate or who spent their days in bed. However, their preference was not recorded in the care plans if they wanted their door open and their dignity was not considered where they were visible by any visitors in the home.
- Care plans were stored in a secure office.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●People told us that they were happy with the care they received. One person said, "No complaints at all except I have to wait when I press the bell to go to the toilet. it is maybe only 5 minutes but feels a long time when I need to go to the toilet." Another person told us, "I get what I need." Relatives gave mixed views about care received, this was mainly because of staffing issues where they told us people waiting for support to get washed and dressed. One relative said, "They need to pull their socks up a bit."

●We reviewed care entries in the electronic records and found that at times people were waiting six hours in between continence care. For example, they may receive personal care at 6am, then again at 12.30pm. No offer of care was recorded between these times, or after breakfast. Staff said it may be due to the internet signal meaning they were unable to update the notes. However, this did not account for the number of entries in a 24-hour period which still indicated long periods of time without continence checks.

●Care plans were detailed and included enough information for staff to be able to support people for basic care needs. However, they did not include all elements of people's needs and some areas were not completed or accurate. For example, there were no plans to support people with any needs because of living with dementia or the behaviours that may challenge.

● Staff knowledge and responses to the needs of those living with dementia needed further developing. For people who were calling out, there were no interventions or strategies to help alleviate people's anxiety or behaviours.

●There were no tactile objects around the home for people to hold or see. For example, blankets that could be used by people who spent time in bed to stimulate their senses. One person was seen to have a doll. However, we did not see staff interact with the person or the doll or provide facilities for the doll should the person have wanted to lay it down.

●The management team told us that staff who were dementia champions had left the service. However, this shortfall had not been identified and there were no plans in place to improve the experience for people living with dementia and ensure staff were sufficiently trained to support the high number of people living at the home who were living with dementia.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People who were able to participate in group activities told us that they enjoyed those provided. One person said, "Plenty of things going on. Yesterday we had a church service. We have bingo, jigsaws, board games, films. Not been on any trips."

● However, people in their rooms had little stimulation. We saw people lying in bed, sometimes with no TV or music, and nothing to look at other than the plain ceiling or wall.
●Staff told us that they did not always get time to go to people's rooms and give one to one activities. One staff member told us that the management team had told them if they managed to visit rooms once a week this was acceptable. We asked the management team what their expectation of rooms visit frequency was. They told us that twice per week was acceptable.
●Staff told us they used to be able to provide more interesting and personalised activities but due to the increase in people's dependency levels in the home and the 'tasks' to be completed, it not been possible in recent times to do these activities. They told us that they had new sensory kits for use with people cared for in bed but have not had the capacity to use them yet
● People told us that they relied on their own independence and family members to arrange to go out. There had been one outing this year which was cut short due to staffing transport issues. The management team told us there were now plans for a weekly outing.
●An activity leaflet was displayed on communal area notice boards. We saw that these activities offered were generic and did not consider people's individual preferences.
● On the day of inspection, we saw there were no activities taking place. One staff member had come in on their day off to take a person shopping. A relative told us that they had seen this happening previously too.
●The management team told us that one of the activity organisers was on leave and one had additional roles to fulfil. As a result, they had been advertising for a new activity organiser to fill the gap. However, no interim measures had been put in place during this process.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider was not meeting this standard as there were no aids available to support people with communication when they were unable to verbalise choices. Staff did not show visual prompts to people.

Due to improvements needed in relation to supporting people living with dementia, to the way people were supported to communicate and a need to further develop activities so that they meet everyone's needs, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
Improving care quality in response to complaints or concerns
● Records indicated that complaints and concerns had not been fully investigated and responded to. There was no review system in place to have oversight of themes and trends of issues in the home and ensure that all action had been taken.
● People and their relatives gave mixed views about the response to complaints. One person said, "Never had to make a complaint." A relative told us, "I have had to complain a lot more now than I had to when [relative] first came." Another relative told us, "[Acting manager] and [Unit manager] really listen. They told me to come straight back to them if there are any more issues."
The lack of oversight and appropriate management of complaints was a breach of Regulation 16 of the Health and social Care Act (Regulated Activities) Regulations 2014

End of life care and support
● The service offered end of life care. When people were nearing the end of their lives, care plans were put into place for supporting people.
● These plans were completed in detail when people approached the end of their lives and they stated if a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) was in place. The persons preferred place of

death was noted and to keep people comfortable. Just in case medicines were prescribed for people nearing the end of their lives. This meant that people were supported to die in a pain free and dignified way.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to inadequate. This was because the provider has repeatedly been unable to achieve a rating of Good.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

● Since November 2014, The White House Nursing Home had been inspected seven times prior to this visit. Out of those previous inspections five were rated as requires improvement and one was rated as inadequate. Four of those inspections resulted in breaches of Regulations. Six of the seven inspections found shortfalls in relation to the governance systems in the home. At this inspection, the eighth inspection in five years, we found that the governance systems remained poor and there were further breaches of Regulations.

●The management team had not used the internal governance systems to help them identify issues in the home. Following a recent local authority visit it was identified that care plan audits were needed. This was only implemented following their advice.

●Some systems had been used to have some overview of issues in the home until April 2019 when the monitoring stopped, however this had not been used consistently. These systems included falls monitoring and weight overviews. Where a wound tracker was completed, this only included what the wound was but not where it was acquired, it's progress and the number of injuries each monthly to help provide analysis and overview of if the plans or care provided was effective.

● Falls monitoring had not been used to inform staffing or to prompt completion of people's dependencies.

●The management team had not ensured that the principles of the mental capacity act had been adhered to. The systems in place did not identify that the correct process was not always being followed and some records were not in place.

●Systems were not in place to ensure fire drills were carried out regularly, to ensure the fire risk assessment was reviewed and to ensure there was a working fire policy in place which set out requirements in accordance with safety regulations.

●The management team had not ensured there were no gaps in recording, and systems had not identified that there were gaps in recording. We also found in medicines records and care plans, in some places they had another person's name typed into the text. This had not been identified by the management team. If entries were missed, indicating care needs may not have been met, this was not followed up by the management team.

●The management team had not ensured that staff levels gave people the care they needed and deserved. They had not assessed dependency and satisfied themselves that staffing levels were enough.

● The management team and provider had not identified that there was insufficient records and monitoring for unexplained injuries.
●Recruitment processes had not been robustly followed despite having a management check form completed. This had not been identified.

Working in partnership with others
● The management team had been working with other agencies to help make improvements. They had reported concerns in relation to allegations of abuse and reported serious injuries appropriately. However, where people had unexplained injuries, there was not an overview to demonstrate that all unexplained injuries had been reported.

Continuous learning and improving care
● The learning from the home's recent issues and ongoing performance issues had been shared with the home's staff for any required actions to be taken. However, this had not been effective in relation to governance and provider monitoring.
● The provider had been informed by the CQC that they needed to implement effective governance systems at all inspections. They had failed to take this seriously and take the required action to address the repeating shortfalls.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
● Not everyone who lived at the home knew who the manager or provider was. One person said, "I don't know who the manager is." The provider and staff told us that the previous manager rarely left the office and didn't offer support to people.
● We were told by some people, relatives and staff that the provider, acting manager and unit managers were available if anyone needed to speak with them. One relative said, "The owner is here every day."
●A staff member told us, "Much happier now, we work as a team and enjoy our job. We feel supported."
●The provider was at the home daily. They told us that they did a walk round every day and identified any issues and acted on them straight away. They told us they kept a record of these checks. However, when asked they were unable to provide us with them. The most recent provider audit record was dated 30 July 2018. The provider had completed a night visits report for January 2019. On this visit they found a night staff member sleeping and noted that they were surprised that this happened as part of a break. No follow up action was noted.
●The acting manager told us that they carried out spot checks and addressed issues as they found them. However, they had not kept a record to demonstrate their findings or help them identify any themes.
●The lack of monitoring systems meant the management team and provider had not identified or addressed the concerns supporting people living with dementia, activities provision or records. Although they were a member of a local care provider's association there was a lack of innovation and knowledge relating to best practice. This demonstrated that the provider was not committed to providing high quality or person-centred care.

Due to the continued shortfalls and governance issues found as part of this inspection, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff
● People and their relatives had meetings to discuss the service.
● The resident meetings looked at activities and menus and gave some information about the home. This included recent inspection visits or contact from the CQC and local authority.

- Care staff meetings included reminders of good practice.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure people's safety was promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that people were protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure that complaints were effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that there were enough staff to meet people's needs at all times.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider continued to have poor governance systems and there was a persistent lack of quality monitoring.

The enforcement action we took:

We imposed conditions on the registration to help drive improvement.