Medical Resources Worldwide Limited

The White House Nursing Home

Inspection report

Gillison Close
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Tel: 01462485852

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 8 June 2017 and was unannounced. At the last inspection on 08 September 2016 the service was found to be meeting all the standards we inspected. At this inspection we found that they were still meeting the standards, however there were areas which needed improvement.

The White House Nursing Home provides accommodation and personal care for up to 67 people. At this inspection 63 people were living at the service.

The service had a manager in post who had recently applied to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

There were systems and processes in place to monitor and address issues at the service. However in some occasions we found that these were not working effectively.
People`s care records were not consistently accurate. We found that some care records gave conflicting information about people's needs and were not sufficiently detailed for staff to know how to meet people`s needs.

People were supported by staff to eat sufficient amounts. Those people at risk of weight loss were regularly weighed and monitored and referred to specialist health professionals if there was a need for it. However at meal times people did not always receive personalised care, staff often supported three people at the same time and at times staff were not attentive to people who were having difficulties eating their meals independently.

People told us that staff were kind and they received care that met their needs. People who were able to were involved in planning their care. For people who were assessed as lacking capacity their relatives were involved in planning their care. However we found that not all the relatives who consented to people`s care had lasting power of attorney for health and welfare.

Mental capacity assessments were carried out in most cases to assess if people were able to make informed decisions about matters affecting their health and welfare; however we found that these lacked detail about the decisions made.

People were treated with dignity and respect and they developed positive relationships with staff.

There were enough staff employed at the home to meet people`s needs in a timely way. Recruitment processes were robust and helped to ensure that staff working at the home were of good character and suitable for the roles they performed.

People's medicines were managed safely by appropriately trained staff who had their competencies checked and followed best practice when administering people`s medicines. Staff were aware of the risks to people's safety and welfare and they knew how to mitigate these.

People were confident to make a complaint if they needed to and told us it would be addressed. There were meetings for people, relatives and staff and their views were listened to and acted upon.

People were offered opportunities to pursue their hobbies and interests in group or individual activities. Staff also regularly spent time with people who were not able to leave their rooms.

Staff had training and support from the management team to carry out their roles effectively. Some staff were trained as champions in areas such as nutrition, dementia, end of life, infection control and they were regularly involved in training and coaching staff to improve their practices.

People, relatives and staff told us that the management in the home was visible and approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about safeguarding procedures and how to keep people safe from the risk of abuse.

There were enough staff to meet people`s needs in a timely way.

People's individual risks were assessed and managed.

Recruitment processes were robust.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always provided with support to help them eat independently.

The mental capacity assessments carried out for people who may have lacked capacity were not always explicit.

People were supported by staff who were trained and felt supported.

People had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People told us staff they felt involved in their care.

Confidentiality was promoted.

Is the service responsive?

Good

The service was responsive.

People told us they were supported to pursue their hobbies and interests.

People told us staff delivered care and support in a personalised way.

Complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The results of the audits carried out by the registered manager and other staff were not collated and analysed for actions resulting to improve the service.

There was no robust system in place to calculate the staffing levels based on people's dependencies.

The provider did not have arrangements in place to audit the quality of the service provided.

People, relatives and staff were positive about the registered manager and the improvements that had been made.

The registered manager was open and honest and dedicated to improve the quality of the service people received.

The White House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and 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 08 June 2017 and was unannounced. The inspection was carried out by two inspectors. Before the inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also reviewed the information we held about the service, notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with six people who used the service, five staff members, two relatives, the clinical lead, the assistant manager and the registered manager. We viewed information relating to six people's care and support. We also reviewed records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "I am safe. I have my call bell and they [staff] get me what I want." Another person told us, "Staff are very friendly and helpful. They [staff] do make me feel safe." Staff were knowledgeable about safeguarding procedures and how to keep people safe. They told us how they would report their concerns internally and externally. Information on how to protect people from the risk of abuse was available and staff knew how to report concerns if they arose.

People told us staff responded quickly to their call bells and they felt their needs were met in a timely way. One person said, "If I ring my bell staff are quick in coming. They know I am totally dependent on them and they are really good." Another person said, "Staff are always popping their heads around to see if I am ok. I think there are enough of them but some are leaving and new ones are coming. They are all good." Relatives told us they visited different times in the day and they felt there were enough staff around at all times.

Recruitment processes were robust and helped to ensure that staff employed at the home were fit to carry out their responsibilities to care and support people in a safe way. Before they could start work staff recruited had undergone appropriate pre-employment checks. These included criminal records checks, references and proof of identity. The registered manager ensured they recorded and investigated in the interview process if staff applying to work in the home had gaps in their employment.

People's individual risks were assessed and there were plans in place to mitigate these risks. Staff were aware of the risks to people's safety and welfare and responded promptly to them. Where people were at risk of developing pressure sores, staff had completed the appropriate assessment and regularly updated this as people's needs changed. Those people who required regular repositioning received this as required and equipment such as pressure mattresses and cushions were in place to mitigate the risk of pressure ulcers developing.

The registered manager told us that staff were prompt in reporting concerns or injuries and documented these in people's care plans. Where staff did report incidents to management, these were completed at the time of the incident and where necessary an investigation to further determine the cause had been undertaken. The registered manager maintained a log of all incidents reported to them, and ensured necessary actions were taken, such as referral to specialist, or referral to safeguarding authorities. For example they discussed an incident with the conduct of a staff member that they reported to safeguarding and took disciplinary action against. However, we found examples of incidents that had been noted in people`s care records but not reported to the registered manager. For one person these related to injuries they had sustained and could not be explained on three separate occasions. The registered manager agreed that these should have been reported both to them and possibly to the safeguarding authorities and proceeded to investigate this.

People received their medicines from competent staff who were trained in the safe administration of medicines. One person told us, "They [staff] bring my medicines every day on time. I know how many I take and what they are for." Medicine administration records (MAR) were accurately completed and signed by

staff after they administered people`s medicines. We found no gaps in staff`s signatures for administered medicines and all the medicines we counted were correct and accounted for. Nursing staff regularly audited medicines and ensured that people had their medicines at the right time and as intended by the prescriber.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met that service was working in accordance with the MCA and DoLS guidance. Appropriate DoLS applications had been submitted and were pending authorisation. People were asked for their consent before care was given and were involved in decisions about their care. People's care plans contained a range of documents that had been singed to indicate that people agreed and consented with the decisions made relating to their care, when they were able to communicate. One person told us, "They [staff] ask me what I want and they do it. If not I would soon tell them, but they are very good."

However we found that some of the MCA assessments were sparse and lacked detail about the decision made. For example we saw authorisations from the GP, pharmacist and family for some people to receive their medicines covertly (covert administration means that the medicines are administered for people in their food or drink without them knowing) ; however there was not always an accompanying MCA or best interest record to evidence that the person lacked capacity to make such a decision. Staff had concluded that administering the medicines was in the person's best interests, without first considering other options, such as using liquid medicines as opposed to tablets.

Power of attorneys (POA) had been declared as being in place by people's relatives. POA`s give relatives the legal authority to make decisions and act on behalf of people. However when checked we found that these were not for health and welfare in all examples, but for property and financial matters. This meant that consent for those people protected by a power of attorney did not have their consent obtained lawfully. The registered manager told us they would immediately review all files for the correct POA and if found to be incorrect they would take action. This was an area in need of improvement.

People were supported by staff who had received training to enable them to carry out their role. One person said, "I have to say the staff are all very good and certainly appear to support each other as a team." Another person said, "Staff knows my routine well and they know what they are doing." We observed staff working in accordance with their training and they told us they felt supported in their roles. One staff member said, "Supervision is every two months, the training is good and we have a monthly team meeting so I feel very supported."

Some staff were trained to become champions for areas like wound care, dementia, safeguarding and

engagement as part of the complex care premium programme developed by the local commissioning group and an independent care provider. The registered manager offered specialist training in other areas to support staff development. Significant numbers of staff had attended the dementia training. We found that staff had not received training in areas such as nutrition, swallowing, tissue viability and oral healthcare and a very small percentage of staff had completed care plan training or pressure ulcer prevention. Opportunities for staff to develop their skills were available, however where not provided consistently, or in a planned manner. The registered manager told us that staff were provided with supervision regularly and also had their skills and abilities observed through competency assessments. They also told us that they were aware some staff did not have an up to date annual appraisal, however they hoped to complete this by August 2017.

Impromptu training sessions known as 'Little Bite' sessions were held by the champions in the home to enhance staff`s knowledge. For example we saw that the wound champion held a session with staff to discuss the use of various dressings for wound care. Other multi-disciplinary discussions for learning were noted to be around falls for a particular person and looking for ways to improve staff awareness and managing chest infections and behaviours that may challenge others proactively.

Training provided to newly employed staff as part of induction included health and safety, safeguarding, fire awareness and moving and handling. However, safeguarding vulnerable adults training was refreshed every three years which meant that staff`s knowledge about changes in legislation around this subject may not have been up to date.

Training about dementia awareness had been provided recently to people`s relatives and had been attended by eight people`s relatives. Feedback from this session had been positive, and the registered manager told us they planned to hold further sessions in the future, although acknowledged uptake had not been as many as they expected.

People were supported by staff to eat sufficient amounts. One person told us, "I do like the food and I can have as much as I want." Another person said, "Oh! Yes the food is excellent and plenty of choices are offered."

Those people at risk of weight loss were regularly weighed and monitored and referred to specialist health professionals if there was a need for it. People were provided with adequate fluids through the day; however staff had not always recorded when people had consumed a drink. This meant that fluid monitoring charts were not always accurately reflecting the amount of fluid they had. The environment at lunch was disorganised and not effectively managed. Staff congregated at the servery to take people their meals, although appeared unclear with what each person was having for lunch. Although alternatives were provided to people, such as pancakes and chicken to meet their preferences, these were not readily prepared when required.

One group of people in the dining area were sat together and looked content with their meal, regularly commenting on people coming and going outside, and having a pleasant discussion over their lunch. However, other people at meal times were not supported as required. People were not provided with adequate cutlery to assist them eating, such as using a spoon or having their meal cut up for them. Plate guards were not used but could have been in place to maintain people's independence. At breakfast in the lounge staff were observed to assist three people at once, moving between them assisting them with their drinks and food. Condiments were not provided for people, there were none available for those people who ate their food in the lounge or bedrooms, and were not consistently on every table in the dining room. This was an area in need of improvement.

People had access to health and social care professionals as needed. We saw that people were visited by their GP, occupational therapists, dentist, chiropodist and a hairdresser. People were also supported to attend hospital appointments when needed.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "They [staff] are lovely and very caring." Another person told us, "I really like it here. I know them [staff] all and they are kind to me." A relative told us, "They [staff] are very nice to us and to [person]. We trust them completely that they keep [person] comfortable."

People told us staff were attentive and protected their dignity and privacy. One person said, "I am very comfortable with them [staff] and they are mindful of my dignity." Throughout the inspection we saw staff supporting people both to maintain their independence, but also their dignity. When staff assisted people with personal care, they did so behind a closed door and placed a notice on the door to help ensure that people would not be disturbed whilst being bathed or changed.

Staff approached people throughout the day to check whether they required assistance with their continence needs, but did so in a quiet and respectful manner that did not alert other people in the room to the assistance the person required. We observed one example where a person's hearing aid battery had died and they were having difficulty understanding what was said to them. Staff were quick to identify the issue and quickly replaced it.

Staff were seen to interact with people in a kind and caring manner, they had clearly built a close rapport with both people and their relatives. We heard frequent discussions throughout the inspection with people, or their relatives regarding people's needs and how these had changed. Whilst discussing people's needs staff were observed to clearly be listening to people and responding to those requests in a manner that was as the person requested.

People's preferences, choices and life histories were documented and staff were aware of these. People were involved in the planning of their care and they, in many cases, had signed to demonstrate this. There was information about advocacy available should people require it but at the time of the inspection people did not need this service as they had relatives or friends who were able to advocate on their behalf if needed.

Care plans were held securely to help ensure confidentiality was maintained. However, we did note that staff not always ensured they secured other records about people`s care. This was addressed by the registered manager on the day of the inspection and a lockable cabinet was provided for care records to be kept secure.

Good

Is the service responsive?

Our findings

People told us that their care needs were met. One person said, "I am very well looked after and staff are great." Another person said, "Of course I miss my old life but here is my home and I like it very much. Everyone is nice and I get to do what I want and need." A relative told us, "We are very happy how [person] is looked after. The more frail [person] gets they [staff] are even more attentive."

We observed staff assisting people in a way that met their needs. For example, we heard staff encouraging a person to eat and drink. They offered the person choices including their favourite drinks. Staff were able to tell us people`s likes and dislikes and how they supported people in a personalised way.

People's care plans had been well developed and they provided staff with clear guidance on what people needed with all aspects of their lives. This included personalised support for personal care; support with communication, activities they enjoyed and these were reviewed each month. The registered manager and staff team had spent time developing these plans to help staff deliver care that focused on the person's individual care needs and preferences. Staff told us these were much improved. One staff member said, "We worked hard this past year and you can see the results." However we found that care plans needed further personalisation to capture all the details staff knew about people`s likes, dislikes and preferences.

People were encouraged to be involved with activities that they were personally suited to. One person told us, "There is always some kind of entertainment going on but I only go to the ones I am interested in. They [staff] will let me know." Another person said, "There are activities all the time. It is my choice to sit more in my room but I am never bored." We observed both group activities occurring with morning chair exercises, but also one to one activities. For example one staff member was sitting with a person reminiscing about kitchen products and ingredients whilst looking at pictures in a book. Both people were seen to be engaged and thoroughly enjoying themselves whilst reliving past favourite meals and foods.

People and their relatives were able to attend regular meetings to raise any concerns or suggestions with the management team. Relatives meetings were held via a forum and chaired by one of the relatives. These meetings discussed areas such as the champion roles, relative training, staffing levels and activities. Copies of the minutes were available and the chair of the meeting met with the registered manager to provide feedback. Attendance at these meetings was low and had been discussed, looking at alternative times and days to hold them in future, however, it was not clear from these minutes how the feedback and updates on actions flowed between the registered manager and chair of the meeting. The registered manager agreed they would formalise the system of feedback to the meeting on their actions and challenges facing the home, and that the meeting would also reflect on areas of good practise and what has worked well in addition to ideas and suggestions for improvement.

People were also provided with regular opportunities to raise concerns and suggestions. One person told us, "If I have a complaint I ask the staff to get the [registered] manager. They will sort it out." Another person told us, "I know who the [registered] manager is and the assistant [manager]. They are very nice and will listen to anything I have to say." Minutes of residents meetings showed that people clearly felt able to raise issues

with the management team. For example in December 2016 people raised an issue with call bell response times. They discussed this at the meeting and subsequent meetings demonstrated this had improved and people were satisfied with the response times.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff were positive about the leadership in the home. One person told us, "The [registered] manager is very nice. They know what`s going on." One staff member said, "[Registered manager] is very good and they managed to bring the team together. I learned and developed more in a year than I did in many before." Another staff member said, "There is a lovely team now and the [registered] manager is not afraid to get their hands `dirty`. They often come on the floor and help."

Staff meetings were regularly held in addition to learning discussions around particular areas of practise. The meetings were documented and allowed staff to raise concerns or questions with the registered manager. We saw recent discussions included rota's and staffing, additional training opportunities, recruitment and staff leaving and reporting incidents. However there were no standard agenda items such as health and safety, safeguarding, staffing, and areas of good practise included in the meetings. Although information about safeguarding concerns were shared in these meetings with staff there were little discussions with staff on how things could have been managed differently. The registered manager told us they will include standardised agenda items for staff meetings.

People`s care records were not always accurate in giving staff guidance on how to meet people`s needs. We found that some care records gave conflicting information about people's needs, and did not record in sufficient detail for staff to know how to respond to a person's needs. For example, we showed the registered manager one person's file and looked at references made about the persons challenging behaviour they displayed at times. When we looked in the corresponding care record, there was no mention of how staff should respond to this, or any distraction techniques they could use to help calm the person. End of life care plans were not thorough enough when considering how to provide care to people nearing the end of their life. Care plans recorded people`s wishes, for example if they wanted their relative to be informed if their condition worsened, if they wanted to remain at the home and funeral arrangements. However care plans did not address in detail how to keep people comfortable and pain free or how to maintain their dignity. Care plans for continence needs did not document frequency of pad change, type of pads to be used. However we found that staff were knowledgeable and knew how to meet people`s needs.

We asked the registered manager for a service development plan that was shared among themselves and the provider in addition to the management team. They told us they did not have an overarching plan. They told us the provider visited the service, however did not formally review or assess the quality of care people received. The registered manager did have an action plan in place that was as a result of a local authority monitoring review, however this was not an improvement plan developed from their own systems. The registered manager told us, "Every month we look at incidents and falls and we share any issues through the daily meetings or staff meetings every month."

We looked at a copy of the incident analysis for the previous month. This had recorded there had been 23 incidents the previous month in areas such as falls, bruising, skin tear. However these were looked at collectively and not categorised in any way to help identify trends and patterns. For example, although the audit identified that nine incidents occurred in people`s bedrooms and eight in the lounge there were not

analysed if these were falls or other accidents. Times had been identified when incidents occurred, but once again, as they did not categorise the type of incident this did not allow the registered manager to use the tool to review areas such as staffing levels at particular times to address a high level of un-witnessed falls.

We identified three incidents for one person who had suffered an un-witnessed injury that had not been reported to the registered manager, and subsequently not included in the recent audit. This meant that although there was a system in place to monitor incidents this was not robust enough to enable the registered manager to effectively review and respond to incidents across the home.

The registered manager told us they monitored staffing levels by their observations within the home, and they also completed a monthly dependency assessment for each person. However the results of the dependency levels were not centralised for the registered manager to be able to effectively monitor any changes in needs. They solely relied on knowing the people in the home and for staff to report changes in their needs. This meant that the registered manager was unable to see the overall changing needs of people to assist them with reviewing and monitoring their staffing levels.

The registered manager was very passionate about developing the service and deliver high quality care for people. They acknowledged that they required stronger governance systems in place to enable them to effectively monitor and review the quality of care people received. They made contact with a local training provider to seek advice and guidance in developing a more effective governance system.

Notifications were made as required by the registered manager of events they are required to inform the Care Quality Commission of.