Care Quality Commission

Valorum Care Limited

White Windows

Inspection report

Fore Lane
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
White Windows is a residential care home providing accommodation and personal care to up to 25 people. The service provides support to people with a range of physical and neurological conditions. At the time of our inspection there were 22 people using the service. White Windows is also registered to provide personal care to people in their own homes.

CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating.

At the time of inspection White Windows was not providing any personal care to people in their own homes.

People's experience of using this service and what we found
The provider's systems and processes were not always effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service. The provider had quality monitoring processes in place, but these were not consistently applied to enable them to identify and address the issues we found during the inspection. This placed people at risk of harm.

Care plans were not always consistently reviewed and updated as people's needs changed. People were supported by staff who knew them well and were able to identify people's likes and dislikes. How people and their relatives were involved in the development of care plans and risk assessments was not always clear. Therefore, we were not assured care plans and risk assessments were always person centred.

Systems in place to manage medicines were not always effective, records to show topical preparations such as creams were being applied were not always completed; therefore, we were not assured people's skin was cared for properly. This placed people at risk of harm.

New staff received an induction programme and most staff had completed a range of training which gave them the skills and knowledge to care for people. Staff told us they felt supported by the acting service manager.

Governance systems were not always in place to ensure all aspects of the service were reviewed and checked regularly. This placed people at risk of harm. The provider had systems to monitor accidents and incidents and used these to identify lessons learnt to the improve the service.

People and their relatives told us they were provided with safe care. People were not always treated with dignity and respect. Staff cared about and had positive relationships with people.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

People were not supported to have maximum choice and control of their lives and 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.

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

Rating at last inspection
The last rating for this service under the previous provider was requires improvement published 17 September 2019.

Why we inspected
This was a planned inspection based on the date of registration.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management of risks and medication, and the provider's systems of governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe. Details are in our safe findings below	**Requires Improvement**
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 always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

White Windows

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by three inspectors and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
White Windows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. White Windows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. An acting service manager supported by a regional operations manager and quality manager, were ensuring interim management cover was in place to support the home and the staff team.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people using the service and nine relatives. We spoke with 15 staff and one volunteer, this included; the acting service manager, regional operations manager, quality manager, activities coordinator, administrator, care staff, team leaders, catering and domestic staff. We reviewed a range of documents including four care plans and other records of care monitoring. We looked at multiple medication administration records. We reviewed a variety of records relating to the management of the service.

Following our visits to the care home, we continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● It was not always clear how people's assessments prior to and on admission were being utilised to develop their care plans, ensure their safety and that of other people. For example, there were no risk assessments in place for a person identified in a referral to mental health services regarding complex behaviour. This put people at risk of not receiving care and support which meet their specific needs.
● Some care records included a risk management section relating to the particular area of care. The risk management was detailed and included information about minimising current risk and potential signs of future risk for staff to be aware of. However, in care records with newer documentation, we could not always find risk assessments. For example, there were no risk assessments for a person assessed as being at risk of malnutrition. Inconsistent care records meant there was not always evidence to demonstrate risks to people's health and safety were being effectively assessed, monitored and mitigated.
● Where people were at risk of losing weight, records were in place to monitor their consumption of food and fluid. These records were inconsistently kept. This meant staff could not be sure whether those people were eating and drinking enough to improve their health or remained at risk.
● Detailed Personal Emergency Evacuation Plans (PEEP's) were included in care records and in some people's bedrooms. This provided staff with a quick reference to support people safely out of the area in an emergency. However, they were not available in all bedrooms.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2002 (Regulated Activities) Regulations 2014

Using medicines safely
● At our visit, care staff competency assessments to administer medication had not been completed in line with the provider's own policy. However, the acting service manager, assured us training and competency checks had been planned and scheduled.
● Records to show topical preparations such as creams were being applied were not always completed; therefore, we were not assured people were receiving these medicines as prescribed.
● Records about the application of medicine patches did not provide assurance the site of application was being rotated safely. This meant there was a risk people might suffer from skin irritation.
● Medication audits were not robust, for example, where issues had been identified, corrective actions had not been completed to address the identified concern.

Systems were either not in place or robust enough to demonstrate medicine were safely and effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Checks on staff recruitment files showed not all gaps in employment had been explored with staff prior to their employment. One recruitment file held information about two other members of staff. We saw in one file that an application for a Disclosure and Barring Service (DBS) check had been made but it was not confirmed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The administrator told us complete records were held centrally at the head office.
● People and their relatives told us there were a number of occasions when there were insufficient care staff. One person told us staff shortages meant call bells were not being answered quickly. The acting service manager told us this was being addressed with increased recruitment.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We noted dirty bedding and furniture in some people's bedrooms. Bumpers covering bed safety rails in some rooms were torn. This made effective cleaning difficult and could pose a risk of cross infection.

● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. The acting service manager clearly set out steps taken during infection outbreak situations, day to day and liaison with infection protection health colleagues, relatives and implementation of infection screening. However, it was not always clear how day to day hygiene was being managed to support people to reduce the risk of the spread of infection. For example, broken surfaces of people's beds and safety bumpers was an infection protection concern. The acting service manager assured us these would be replaced.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
The service supported people in receiving visits from relatives and friends through a booking system. COVID-19 tests were provided to all visitors if they had not completed one prior to visiting the home. PPE was also provided to all visitors to protect people. An area of the care home had been altered to support social

distanced visits as needed.

Systems and processes to safeguard people from the risk of abuse
● One person's care record included a referral form to mental health services. The referral form said anybody around the person, including other people living at the home, were at risk of violence and aggression and inappropriate sexual language from the person. We did not see evidence of any safeguarding referrals having been made as a result of this referral.
● People and their relatives told us they felt safe with staff, however, one person told us that when there had been only two care staff working on one day, they did not feel safe.
● Staff had received safeguarding training and knew what to do if they thought someone was at risk of abuse.

Learning lessons when things go wrong
● Some staff we spoke to recognised incidents and how to report and record them appropriately. However, we saw at a handover meeting that some staff were not clear about how to report and record incidents.
● There was a system to record individual incidents and accidents, this was collated electronically to ensure oversight.
● The acting service manager and regional operations manager explained how incidents and accidents would be investigated and lessons learnt cascaded to staff.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement.

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

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 MCA 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).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We were not always assured that people's DoLS applications were being routinely checked. For example, one person's care records included a DoLS application dated August 2021. There was no evidence of the application having been followed up. This meant if people had been deprived of their liberty, the legal authorisations to do this had expired.
● One person's care record included a mental capacity assessment form and a best interest consultation and decision form. Neither form had been signed but both had the names of the previous registered manager and the deputy manager printed as involved in the process. The deputy manager, now the acting service manager said they had not been involved in this decision.
● Some people and their relatives told us they were given choices and had control of their care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Preadmission assessments were not always completed for people receiving regular respite care. This meant any change in their needs might not be known to the staff. The acting service manager told us they had started completing pre-admission assessments and we saw evidence of this.

● One person had been identified to the inspection team as displaying behaviours that might challenge. No risk assessment or care plan had been developed in relation to this. This meant that their needs had not been fully considered.

Staff support: induction, training, skills and experience
● Relatives gave us mixed reviews about staff. For example, one relative told us, 'I think [relative's] care is great. Another relative told us they were concerned staff did not have the skill set to meet their relative's needs. This meant we could not always be sure about the quality of care people received from staff.
● Staff told us they had had supervision, however, some staff told us that this was approximately only once over the last year. This meant staff and their supervisors had limited opportunity to discuss their work and impact on the service people received.
● Some staff told us they had had an appraisal, this meant staff did not consistently have the opportunity to discuss their work life and career objectives with their relevant line managers.
● Staff told us they received mandatory and specialist training to enable them to deliver care people needed. We saw evidence the provider monitored staff training requirements and there was good compliance with training required. One staff member told us training was received mostly online and they needed training about using care documentation, as this had recently been updated.
● Staff said they felt involved and supported by supervisors and managers. Staff told us the acting service manager was approachable and supportive.

Supporting people to eat and drink enough to maintain a balanced diet
● Care records included nutrition and special dietary requirements care plans. These care plans did not consistently provide the detail needed. For example, a care plan for a person identified in a mental health referral form as being malnourished which led to skin issues, did not include any mention of malnourishment. The care plan also did not include detail of the special diet the person followed. This meant people's nutrition and special dietary needs were not always fully considered.
● Fluid intake charts did not reflect people had a sufficient fluid intake. For example, fluid charts for a person with a medical condition said they needed to have between 1500 and 2000mls of fluid per day. Fluid charts for four consecutive days showed an intake of between 700 and 750mls. This meant we could not always be sure that people were receiving their required fluid intake.
● Some people we spoke to gave positive feedback about the food they received.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We saw staff had raised concerns about a person's nutrition and they were referred to a specialist service. We identified the referral had not been followed up and saw a malnutrition screening check was not consistently undertaken. This meant the person was at risk of potential harm.
● Care records showed involvement of other health care professional such as GP's and district nurses to meet people's needs.
● Involvement of appropriate health and social care professionals was detailed in the care records we reviewed.
● One relative told us, "The positives are that, [relative] had not been admitted to hospital, and they did let me know about [relative's condition], as an appointment was booked, and they will come and drive me and [relative] there and back, which is good."

Adapting service, design, decoration to meet people's needs
● One person wore ear defenders as they found the noise of the dining area during mealtimes distressing. The acting service manager took immediate action to enable another quieter dining area.

● People were able to personalise their bedrooms and other areas around the home. These reflected their lifestyle choices, interests and hobbies. The acting service manager told us people would be able to choose the layout and decoration of rooms as part of ongoing refurbishment.
● People were able to move freely and spend time inside the home and its gardens as they wanted to.
● The 'call bell', which sounded frequently was very loud in all communal areas. This meant people may have been distracted from activities such as conversations and enjoyment of music or television.

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.

This is the first inspection of this newly registered service. This key question has been rated as requires improvement

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

Respecting and promoting people's privacy, dignity and independence
● One person told us they had been forced to be incontinent as staff did not come quickly enough to support them to the toilet. The person was very distressed by this and meant they felt they were not afforded the dignity they required.
● One person had been supported to the toilet but the door to the bathroom had been left open meaning the person was clearly visible from the corridor. When we asked a member of the management team about this, they said the bathroom door did not close. This meant the person's privacy and dignity was not ensured.
● Staff were able to consistently tell us and give examples of how they had promoted people's privacy and dignity, particularly during personal cares. However, this was not supported by some of the practice we observed.

Supporting people to express their views and be involved in making decisions about their care
● Care documentation lacked evidence of the involvement of the person in the development of their care plans or risk assessments. This meant we could not always be sure people were always in receipt of person centred care.
● There was evidence the provider had included and supported people to lead resident's meetings.
● The activities coordinator gave examples of consultation with people and responding to their needs. However, this was not always recorded.

Ensuring people are well treated and supported; respecting equality and diversity
● A behaviour assessment form for one person detailed how they had asked a member of staff for a biscuit. The staff member recorded their opinion that this request was only made because another person had a biscuit. The staff member told the person they had to wait as they had just eaten a meal. This meant the member of staff had failed to respect the person's choice and resulted in the person becoming distressed and displaying anger.
● There was mixed feedback from relatives about staff. One person's relative told us they were very pleased with the support their relative received. They said they could not speak highly enough of the staff. Another relative said "A manager said [relative] had been rude and would I have a word with [relative], but they should employ people who understand what they're dealing with."
● Staff we spoke to were able to tell us about people's likes and dislikes and how they had formed caring relationships with people and their relatives. We saw evidence staff had respected some people's expressed

equality and diversity needs.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement.

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
● Care plans were inconsistent in their reflection of a person-centred approach to care. Some were written from the point of view of the person and reflected their involvement. Others did not reflect any involvement of the person. The acting service manager told us there was a plan to update all care plans into a new format.
● Care plan reviews did not clearly record how people and relatives had been involved in the review process. Some relatives told us they wanted more sharing of care plans.
● The acting service manager explained how they were undertaking daily walk rounds speaking to all people, asking how they were and about their needs. Whilst this was being recorded, it was not clear how the information gathered was being used to update care plans and risk assessments.
● Staff we spoke to were knowledgeable about people's likes and dislikes and gave us examples how they ensured choice and control. One relative told us "They know [relative] loves drinking coffee and water. So, if they say 'Coffee?' or 'Water?', [relative] shuts or opens their eyes."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The acting service manager explained how information could be provided in differing formats to meet people's needs to make decisions and engage with the service.
● The acting service manager told us updated care plans would have people's communication at the front of the care plan.
● Staff and the acting service manager gave examples of people's non-verbal cues to enable choice and control.

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
● Some people told us they were bored, other people told us there were activities. Some people told us they wanted to be more involved in making choices about the planned activities.

● The activities co-ordinator was enthusiastic about their role and was aware of people's social and leisure preferences. However, in order to meet people's needs they required support from members of the care team. The acting service manager told us they were addressing this issue.
● The acting service manager told us how the COVID-19 pandemic had negatively impacted on meeting people's social and cultural needs. They had a plan to re-energise activities. They explained how he would now ensure one person would be helped to attend church when they wanted.
● One person told us how they had been supported to attend their relative's wedding and how happy that had made them feel. The person told us the service had arranged the transport to the wedding.

Improving care quality in response to complaints or concerns.
● The provider sought feedback from people and relatives. Any concerns raised were dealt with and those involved were updated.
● The provider had a system in place to record, respond to and review any learning from complaints received.

End of life care and support
● The care records we reviewed did not have care plans in place to consider people's individual wishes, values and beliefs at the end of their lives. At the time of the inspection no one was being supported with end of life care.

Requires Improvement

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Auditing systems were inconsistent and did not to meet the provider's own standards. However, a detailed service audit had recently been undertaken and we were informed action to improve the service would follow.
● Governance systems where not always effective in ensuring oversight of the safety of the service. This included the issues we identified in relation to health and safety of the premises and infection control practices.

The provider had failed to ensure that systems for auditing the safety and quality of the service were sufficiently robust to identify risks to people's safety and welfare. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated Activities 2014)

● The acting service manager acknowledged service improvement was needed and showed enthusiasm to address these.
● A new care record system was being rolled out and the acting service manager assured us that this would address inconsistences with record keeping.
● The acting service manager was clear that they were receiving support from the quality manager and regional operations manager to ensure regulatory responsibilities about quality and risk were being managed appropriately. The provider had ensured management arrangements were in place until a registered manager was appointed.
● There was evidence that the provider took an open and transparent approach to concerns and complaints and lessons learnt were cascaded to staff to improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We saw some examples of person-centred care and some people told us the care setting was their home, in contrast, one person told us they felt 'trapped'.
● Staff told us the acting service manager was approachable and addressed concerns quickly.
● The acting service manager was keen to 'reopen' up the home and engage with the local community to address isolation that had been experienced during the pandemic. The acting service manager was working

with a local school to encourage volunteering.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There was evidence to support complaints and concerns were being addressed in an open and transparent way.
● Staff were aware how to raise any concerns if they were to arise and felt confident to escalate their concerns should they need to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us there were staff meetings, however, they were not clear how often these took place, and some told us they did not receive minutes if they could not attend.
● The acting service manager and activities coordinator facilitated regular meetings with people, and they supported people to lead the meeting. The acting service manager told us there was a plan to roll out a survey to seek feedback from relatives.

Working in partnership with others
●Processes were in place to ensure referrals were made to outside organisations as appropriate. For example, support had been requested for people from occupational therapists and dieticians.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1), (2) (a), (g) The provider's systems and processes were ineffective at assessing the risks to the health and safety of service users of receiving the care or treatment. The service did not always manage medicines safely, systems in place to manage medicines were not always safe or effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1), (2), 9 (a),(b) (c) The providers quality assurance systems and processes were not effective and had not enabled them to Assess, monitor and improve the quality and safety of the services