Accomodating Care (Driffield) Limited

The White House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of The White House Residential Home took place on 2 June 2016 and was unannounced. At the last inspection on 28 May 2014 the service met all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were superseded on 1 April 2015 by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The White House Residential Home on the edge of Driffield provides care to a maximum of 20 older people who may have memory impairment. The service is close to local amenities and has transport links to Beverley, Hull and surrounding East Yorkshire. There are single and shared bedrooms, two lounges, a dining room and a rear garden. There is car parking for five cars.

The registered provider is required to have a registered manager in post. On the day of the inspection there was a manager that had been registered and in post for the last three years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. Risks were also managed appropriately so that people avoided injury or harm wherever possible.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Staffing numbers were sufficient to meet people's needs and we saw that rosters accurately cross referenced with the people that were on duty. Recruitment policies, procedures and practices were carefully followed to ensure staff were suitable to care for and support vulnerable people. We found that the management of medication was safely carried out, but we made a recommendation to the registered provider to ensure that practice was in line with guidance produced by National Institute for Health and care Excellence.

We saw that people were cared for and supported by qualified and competent staff that were regularly supervised and received an appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. The premises were suitable for providing care to older people, but there was a recommendation made to ensure that all areas that required repair and / or furniture and items that needed replacement were attended to.

We found that people received compassionate care from kind staff and that staff knew what people's needs and preferences were. People were supplied with the information they needed at the right time, were involved in their care, where possible, and were asked for their consent before staff undertook care and support tasks.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these. This ensured people were respected, that they felt satisfied and were enabled to take some control of their lives.

We saw that people were supported according to their person-centred care plans, which reflected their needs well and which were regularly reviewed. People had the opportunity to engage in some pastimes and activities if they wished to, but there was insufficient activity to stimulate those people living with dementia. People had good family connections and support networks.

We found that there was an effective complaint procedure in place and people were able to have any complaints investigated without bias. People that used the service, relatives and their friends were encouraged to maintain healthy relationships together by frequent visits, telephone calls and sharing each other's news.

The service was well-led and people had the benefit of this because the culture and the management style of the service were open and responsive. There was an effective system in place for checking the quality of the service using audits, satisfaction surveys and meetings.

People had opportunities to make their views known through direct discussion with the registered manager or the staff and through more formal complaint and quality monitoring formats. People were assured that recording systems used in the service protected their privacy and confidentiality as records were well maintained and were held securely in the premises.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were also managed and reduced so that people avoided injury at all costs.

The premises were safely maintained, but the garden had an unsafe surface that had not been addressed for some time. Staffing numbers were sufficient to meet people's need and recruitment practices were carefully followed. People's medication was not always safely managed.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal of their performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. The premises were suitable for providing care to older people and to those living with dementia, but some minor repairs were not attended to and redecoration had not been carried out for some time.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. People were supplied with the information they needed and were included in their care.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities if they wished to.

People were able to have any complaints investigated without bias and they were encouraged to maintain relationships with family and friends.

Is the service well-led?

Good

The service was well led.

People had the benefit of a well-led service of care, where the culture and the management style of the service were inclusive and the checking of the quality of the service was effective.

People had opportunities to make their views known and people were assured that recording systems in use protected their privacy and confidentiality. Records were well maintained and were held securely in the premises.

The White House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of The White House Residential Home took place on 2 June 2016 and was unannounced. One Adult Social Care inspector and an expert-by-experience carried out the inspection. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in care of older people who may be living with dementia.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with The White House Residential Home and reviewed information from people who had contacted CQC, to make their views known about the service. We had also received a 'provider information return' (PIR) from the registered provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people that used the service, three relatives and the registered manager. We spoke with three members of staff that worked at The White House Residential Home. We looked at care files belonging to three people that used the service and at recruitment files and training records for three members of staff. We looked at records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems. We looked at equipment maintenance records and records held in respect of complaints and compliments.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at The White House Residential Home. They explained to us that they found staff to be "Helpful and pleasant." They said, "I feel safe here because no one shouts at me" and "I like the people who are in here and I like the staff that look after me". One relative we spoke with said, "I would not leave Dad here if I did not know he was safe and well looked after." Another said, "We all (family) feel now that [Name] is safe and well looked after."

We found that the service had systems in place to manage safeguarding incidents and that staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents. Staff said, "I would go straight to the manager if I suspected any abuse was taking place or saw anyone being mistreated" and "I've completed safeguarding training and understand my responsibilities."

We saw evidence in staff training records that staff were trained in safeguarding adults from abuse and we saw the records held in respect of handling incidents and the referrals that had been made to the local authority safeguarding team. These had been notified to us by the registered provider through formal notifications, which numbered three safeguarding referrals in the last two years. All of this ensured that people who used the service were protected from the risk of harm and abuse.

Risk assessment forms showed how risk to people was reduced, for example, with pressure relief, falls, moving and handling, mental health, nutrition and bathing and there was a one-page personal emergency evacuation plan. This enabled staff to assist people to evacuate quickly in the event of a fire or other emergency.

We saw that the service had maintenance safety certificates in place for utilities and equipment used in the service that were all up-to-date. These included, for example, fire systems, electrical installations, gas appliances, hot water temperature at outlets, lifting equipment and the passenger lift. There were contracts of maintenance in place for ensuring the premises and equipment were safe at all times. These safety measures and checks meant that people were kept safe from the risks of harm or injury.

However, while we had no concerns about the safety of the premises indoors, there was an area of garden just outside the dining room doors that was paved unevenly and had still not been resurfaced. It was a trip hazard to anyone that wished to access the garden and had been highlighted, as part of the general upgrading of the facilities, at the last inspection. It was unsafe for those with walking difficulties, back then, should they have wanted to go into the garden. At this inspection we saw that one newly admitted person now sited their static cycle in this area and regularly went out to it, which meant that the area was used more often than before. Because the patio surface was still unsafe and the area was being accessed more frequently this was a greater risk to people that used the service. The registered manager informed us that quotes had been obtained from builders to remedy this, but we considered it had not been addressed in a timely manner. This was a breach of regulation 15(1)(e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were accident and incident policies and records in place should anyone living or working at The White House Residential Home have an accident or be involved in an incident. Records showed that these had been recorded thoroughly and action had been taken to treat injured persons and prevent accidents re-occurring.

When we looked at the staffing rosters and checked these against the numbers of staff on duty during our inspection we saw that the roster was reflective of those on duty. There was a cook, a cleaner and three care staff working on the day we inspected. People and their relatives told us they thought there were enough staff to support people with their needs. We asked the registered manager why there had been a high number of staff changes in the last twelve months and they explained this was because of unreliable staff and staff with personal issues that meant they had to resign. These changes in staff could have been unsettling for people that used the service.

During the inspection we saw that at times and particularly after lunch, there were no 'visible' staff around. This may have been due to them carrying out personal care in people's bedrooms, but it left no one available to supervise people in the communal areas. However, we did not observe any situations where people's needs were not met.

Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities and to take time chatting to people and assisting them with some pastimes or activities. One staff member said, "Staffing levels are very good here, we cover each other's leave and never find ourselves working alone. If ever we are struggling then seniors and the manager will help. We have a few people that need two staff to assist them sometimes and these people are always cared for by two of us."

The registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, references taken and Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults. This checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Recruitment files we looked at contained evidence of job application forms, references, DBS checks, induction checklists, terms and conditions of employment, staff identities and correspondence about job offers. We assessed that staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for the simple administration of measured doses given at specific times.

We saw that medicines were obtained in a timely way so that people did not run out of them, that they were stored securely, and that medicines were administered on time and recorded correctly. However, there was no means of ensuring that the medication storage room was kept at a sufficiently low temperature. The room temperature was not routinely checked as being below 25 degrees centigrade; the maximum safe temperature to store medicines at to ensure their effectiveness. The registered manager said they would attend to this as a priority.

Unused medicines were disposed of as efficiently as possible in that they were placed in a separate container and recorded in a returns book at the same time, ready for collection by staff from a local pharmacy.

While controlled drugs in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001) had been handled appropriately a number of them had yet to be returned to the pharmacist. There were some anticipatory drugs (for end of life) that had not been returned following the death of three people and the discharge back home of one person in the last few months. This had not been completed in a timely manner. However, the staff had endeavoured to have these medicines collected by the pharmacist as soon as possible after they were no longer required, but had not followed up with the pharmacist to ensure they were collected. There were other anticipatory drugs left over for another three people that had recovered from their illnesses and no longer required them. These had also not been returned in a timely manner, but the staff had kept them on the advice of the prescribing GP, so that they were easily accessible in the future. The registered manager undertook to have them returned and assured us this would not occur again.

When asked about their medication needs people said, "I am given my medicines on time and correctly and my Warfarin is checked monthly by my GP" and "I like to look after my own medication, as I have a right to." One person exercised their right to independence and autonomy as much as possible and sometimes purchased their own pain relief. The registered manager said it was difficult for the staff to keep a check on how much the person had taken and when. Discussion between the person and the registered manager took place to try to resolve the issue, but an agreement could not be reached at the time. The person was determined they would continue to obtain pain relief and so the registered manager decided to look at the possibility of risk assessing the situation to enable the person to be in control of acquiring their own 'over the counter' pain relief.

We recommend the registered provider follows the National Institute of Health and Care Excellence guidance on the safe management and storage of medicines, with regard to storage room temperature and disposal of unused CDs.

Good

Is the service effective?

Our findings

People we spoke with felt the staff at The White House Residential Home understood them well and had the knowledge to care for them. One person said, "I do think staff know what they are doing, they look after me very well." One visitor we spoke with gave the opinion, "I feel most of the staff have the training and skills to do their job."

We saw that the registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. The registered provider had an induction programme in place and reviewed staff performance via one-to-one supervision and an appraisal scheme.

Staff told us they had completed mandatory training (minimum training as required of them by the registered provider to ensure their competence) and had the opportunity to study for qualifications in health care. One staff said, "I've completed dementia awareness course in the NVQ level 2 and am now doing level 3." Another staff member said, "I've completed training in safeguarding adults from abuse, health and safety, care of the dying, fire safety, oral health care and dementia awareness, as well as the mandatory training courses." A third staff member said, "I am aware of the Mental Capacity Act and DoLS in place but I haven't done any training on these yet. I am quite happy to if I get the chance. I've completed some equality and rights training in respect of people living with dementia. My induction was a two day one as I was already an experienced carer before I came here and I have completed moving and handling and hoist training."

We saw three staff files that confirmed the training staff had completed as well as the qualifications they had achieved. We saw that staff had received individual supervision regularly and that appraisal scheme meetings with staff were held and recorded.

We saw that communication within the service was good between the registered manager, staff, people that used the service and their relatives. Methods used included daily diary notes, memos, telephone conversations, meetings, notices and face-to-face discussions. People that used the service and their visitors were seen to ask staff for information and exchanged details so that staff were aware of people's immediate needs.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that staff were trained in MCA and DoLS principles and that there were three people with DoLS restrictions in place. These had been appropriately requested and recorded and the registered manager was aware of when they needed reviewing.

We saw that people consented to care and support from staff by either saying so or by conforming to staff when asked to accompany them and by accepting the support they offered. When asked about the importance of consent staff said, "If anyone refuses to say join in with entertainment or an activity I would respect that, but I still try to encourage them to do something" and "I always ask people to give their consent before I begin to help them. I say 'would you like some help' even though I know they need help."

There were some documents in people's files that had been signed by people or relatives to give permission for photographs to be taken and information to be shared, for care plans to be implemented and for medication to be handled on their behalf. One relative told us, "Mum keeps refusing to have a bath or shower and staff tell me they have asked her but she refuses. They need to be encouraging her rather than just leaving it at that." The registered manager explained that staff would ask several times but if a person continued to refuse they had to respect that. This demonstrated how difficult it sometimes was for staff when they offered people support and they refused to give their consent to it. It showed how conflicting views between staff and relatives could lead to dissatisfaction about care.

People had their nutritional needs met by the service because people had been consulted about their likes and dislikes, allergies and medical diets and the service sought the advice of a Speech And Language Therapist (SALT) when needed. The service also provided three nutritious meals a day plus snacks and drinks for anyone that requested them, particularly at supper time. There were nutritional risk assessments in place if people had difficulty swallowing or they needed support to eat and drink.

Menus were on display for people to see what was on offer and people told us they were satisfied with the meals provided. They said, "The food is quite adequate", "There is a main meal provided and if you don't like that you can have something else" and "I like the food here, it is okay." Staff said, "The food people get here is all home-cooked and of the three homes I've worked in the food is the best here" and "People eat well and have a choice of meals in that there is a set menu each day, but if someone does not want or like that then an alternative will be given to them. One person here is quite a 'faddy' eater and another person has particular dislikes, but they are both accommodated by the cook."

We saw that people had their health care needs met by the service because people had been consulted about their medical conditions and information had been collated and reviewed with changes in their conditions. Staff said, "There is a dedicated file for holding environmental health information and such as any outbreak of sickness and diarrhoea. We had some to deal with just this last January 2016." We were told by staff that people could see their GP on request and that the services of the district nurse, chiropodist, speech and language therapist, physiotherapist dentist and optician were obtained whenever necessary.

Health care records held in people's files confirmed when they had seen a professional, the reason why and what the instruction or outcome was. We saw that diary notes recorded where people had been assisted with the health care that had been suggested for them. For example, one person used oxygen on the premises and this was safely managed within a risk assessment and was identified as a hazard using clear signage.

The premises were safe for use but there were some outstanding repairs and upgrades that had not been

completed. One bedroom had an en-suite shower but it had not been connected up properly and so was useless, another bedroom had severely unpleasant odours and was over-heated and several en-suite toilets had old, worn and stained toilet bowls. One person told us their bedroom had loose casement windows that were extremely draughty in the winter months. Communal toilets had not been upgraded for several years and toilet bowls and floor coverings were not easy to keep clean. We recommend the registered provider upgrades the environment and carries out repair work where needed to ensure people that use the service have a pleasant environment in which to live.

For those people that used the service who were living with dementia, approximately one third of the whole group, we found that signage was suitable for them to navigate their way to facilities like bathrooms and the lounge. While the décor and environment were domestic and without any specialist dementia-friendly facilities we saw that there were no detrimental effects on people's quality of life because of this, as most people had en-suite toilets in their bedrooms, carpets were plain in design and on the ground floor the one main corridor through the home led to people's bedrooms. The same applied on the upper floor: one main corridor with bedrooms off it. There was little opportunity for getting lost or disorientated.

For such time as the registered provider looks at future development of the service in respect of people living with dementia, there is some excellent information that can be found in research undertaken by various universities, leaders in dementia care and reputable sources. These look at reducing the incidence of agitation and behaviour that may be challenging to a service, encourage meaningful activities, increase feelings of wellbeing, decrease falls and accidents and improve continence and mobility.

Good

Is the service caring?

Our findings

People we spoke with told us they got on very well with staff and each other. They said, "Staff are very good; they are all friendly to me. They have always treated me with respect and they always knock on my door before coming in" and with regard to privacy, "They (staff) always turn their back when I am dressing to preserve my dignity. They make me feel comfortable all of the time." One person said, "You couldn't have nicer staff; they are very helpful and will do anything for us." One relative said, "The staff show genuine compassion, for example, I have seen them giving people a hug or just stroking their hand". One staff member said, "I know I've done my job properly if I have made someone smile or laugh, as I see people as part of my family."

We saw that staff had a friendly manner when they approached people and met their needs, as staff knew people well. People and relatives stated how kind and considerate the staff were. We observed staff interactions throughout the day and felt that they were respectful. We also saw that people were clean, tidy and well presented. While staff were helpful we found that they were perhaps a little too relaxed about helping people quickly enough, as one person's bed had not been made and they wanted to lie on it. We heard the person tell the registered manager that the night staff had removed the sheets and thought it was to ensure they didn't go back to bed so soon after getting up. The registered manager made no response to this and gave us no explanation about it, but arranged for someone to make the person's bed. This was discussed later with the registered manager who explained to us that there was a programme in place to offer the person some 'normalisation' in their daily and night time routine. However, we were not entirely clear about staff motivation in this situation.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. One person exercised their independence in contacting their preacher and meeting with them at will. We saw that people with mild learning disability now had greater needs due to their age, but discrimination on the grounds of learning disability could still be an issue for them. However, we saw no evidence to suggest that anyone that used the service was discriminated against in respect of age or disability.

People's care plans recorded their individual routines and preferences for personal care, activities, communication with family members and whether or not they went out and when. They recorded people's differing food preferences and how they wanted to be addressed. Staff knew these details and responded to them accordingly and no one gave us any cause to consider that people were treated unkindly. One relative said, "Staff are compassionate and work together with families. It is like having an extended family; even night staff will ring sometimes just to re-assure me that [Name] is alright" and "I have often been here at 12 at night if [Name] is unwell; staff make me welcome at any time. They bring me food and drinks; nothing is too much trouble for them."

We saw that people who used the service had their general well-being considered and monitored by the

staff who knew what incidents or happenings would upset their mental health, or affect their physical ability and health. People were supported to engage in pastimes they had undertaken in younger life, which meant they were able to 'keep a hold on' some aspects of the lifestyle they used to lead. This helped people to feel their lives were still worthwhile and aided their overall wellbeing.

While we were told by the management team that no person living at The White House Residential Care Home was without relatives or friends to represent them, we were told that advocacy services were available if required. (Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them.) Information was provided on the notice board in the entrance hall.

People we spoke with told us their privacy, dignity and independence were always respected by staff. Staff only provided care considered as personal in people's bedrooms or bathrooms, knocked on bedrooms doors before entering and ensured bathroom doors were closed quickly if they had to enter or exit, so that people were never seen in an undignified state. One staff said, "Confidentiality is always maintained and people's dignity is upheld especially when discussing their needs. As a dignity champion it is my role to 'pull staff up' if they are not ensuring people's dignity and to mentor new staff in the ways of respecting people's dignity." We were informed that there were three 'dignity champions' at The White House Residential Care Home. These are staff delegated to ensure all staff uphold the principles of dignity and take them to task if not. This is so that people's dignity is never compromised and they are treated with respect at all times.

Good

Is the service responsive?

Our findings

People we spoke with felt their needs were being adequately met and that the care and support they received from staff was appropriate and in response to individual needs. Relatives we spoke with felt the staff responded well to people. One relative said, "Dad gets bored but doesn't like group activities so the home have put a package in place for a senior to be able to spend two hours a week on a one to one basis with him." These and other arrangements were recorded within people's care plans.

We looked at three care files for people that used the service and found that the care plans reflected the needs that people appeared to present. Care files included a photograph of each person, their details on admission, assessments of needs, allergies and medication alerts recorded in red ink/type to stand out, a placing authority support plan if applicable, a patient passport, life story book, a dependency profile updated each month, and the care plan. Care plans were person-centred and contained information under thirteen areas of need for instructing staff on how best to meet people's needs in relation to these areas. There were key worker notes and a monthly review evaluation form to show people's progress or deterioration in summary format.

Monitoring charts were in place for people with regard to weight, nutrition, bathing, pressure relief, elimination (if necessary), activities and personal care. One bathing record we saw was poorly completed as it had no entries for a period of two months, then when entries resumed it showed the person had not been bathed for 18 days. We asked the registered manager to look into this as people require and need more frequent baths or showers than was recorded. There were records of hospital visits, district nurse and GP visits, accidents / incidents, optician and dental referrals. We saw that care plans, risk assessments and monitoring charts were reviewed monthly or as people's needs changed, which meant that in the main information about people was current.

An activities timetable was pinned to the notice board but was not clearly visible, being hidden by other papers and not in an accessible format, (for example, large print). The activities were a little limited and observations made during our visit found that staff were not always proactive in offering these. The majority of people that used the service were living with dementia. However, we saw that activities were not of the stimulating / memory type activities, which would be of interest to them or would encourage more interaction. There were no rummage boxes that would be beneficial to those living with dementia so that people were not so reliant upon staff to instigate activities. Staff told us that people often chose to stay in their rooms.

However, people told us they sometimes joined in with quizzes, musical entertainment and gardening. They said, "I can get my nails done and painted," and "I like to take myself out to my friends, whenever I can." There were some activities held in-house with staff. On the afternoon of the inspection visit, people were asked if they wished to play carpet boules and a few people tried it. We saw that some people took magazines, newspapers and puzzle books on delivery and read or worked through these during the day. At one point in the day there was music playing on a CD player. Staff told us that the home was in a competition for indoor bowling and a team practiced each week for their annual competition event at the

leisure centre. One person attended a local day centre once a week. Staff said that they tried to encourage people to join in with activities whenever possible. This meant that people were supported to take part in some activities of their choice.

The service used equipment for assisting people to move around the premises and this was used effectively. People were assessed for its use and there were risk assessments in place to ensure no one used it incorrectly. Staff were trained in the use of lifting equipment such as hoists, slide sheets and supporting belts and there were six 'hoisting champions'. These were staff designated to ensure equipment was used safely by all staff, equipment and slings were maintained and staff training was kept up-to-date.

Bed rail safety equipment was in place on people's beds and these had also been risk assessed for safe use. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. All equipment in place was there to aid people in their daily lives to ensure independence and effective living, but not unless people wanted it and, if necessary a risk assessment had been carried out with each person for this equipment.

Staff told us that it was important to provide people choice in all things, so that they continued to make decisions for themselves and stay in control of their lives. People had a choice of main menu each day and if they changed their mind the cook usually catered for them. One staff member said, "People choose where they sit, who with, when they get up in the morning or go to bed, what they wear each day and whether or not they join in with entertainment and activities or go out for the day." People that used the service said, "I can do what I like. After my dinner, I like to go to my room so that I can put my legs up and watch television" and "I choose when I want to get up in the morning, most of the time I can wash and dress myself but sometimes I ask for help and they (staff) always help me." People's needs and choices were respected wherever possible.

People were assisted by staff to maintain relationships with family and friends. This was facilitated in several ways. Staff who key worked with people got to know family members and kept them informed about people's situations if people wanted them to. Staff also encouraged people to receive visitors and telephone them on occasion. Staff spoke with people about their family members and friends and encouraged people to remember their birthdays, by helping them send cards.

The efforts of the service to support people maintain relationships was further demonstrated by comments from family members and in the display of letters and cards of thanks sent by family members, both of which clearly showed how welcome visitors had felt when visiting and interacting with people that used the service. One person's relatives told us that staff had excellent partnerships with GPs, district nurses and community psychiatric nurses (CPNs). The visitor stated that CPNs and the staff at The White House always keep them informed about their relative's needs and the state of their mental health.

We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within set timescales. There had been five complaints to the service in the last twelve months, which had not been serious but involved problems with laundry and these were appropriately addressed. Complainants had been given explanations and were satisfied with the response to their complaints. People and relatives we spoke with told us they knew how to complain. One relative said, "If I had a concern, I would feel comfortable speaking to the manager. I have never had to complain but on occasions brought things to her attention that need doing in [Name's] room, and she has always been very accommodating and sorted it out straight away."

Staff we spoke with were aware of the complaint procedures and had a healthy approach to receiving

complaints as they understood that these helped them to get things right the next time. Compliments were also recorded in the form of letters and cards. All of this meant the service was responsive to people's needs.

Good

Is the service well-led?

Our findings

People we spoke with felt the service had a pleasant, family orientated atmosphere. Staff we spoke with said the culture of the service was, "Warm and friendly", "The White House is a place I want to come to each day. It is a place of learning too" and "Relaxed, slow and a place where we have time to do the things people need us to do."

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been registered manager for three years.

The registered manager and registered provider were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications were notified under the Care Quality Commission (Registration) Regulations 2009.

Staff told us the management style of the registered manager was open and approachable. Staff told us they could express concerns or ideas any time and that they felt these were considered. They said that the registered manager was there if ever they needed anything, and would work as a care staff member if necessary, though this had not been necessary for some time now.

The service maintained links with the local community through the church, schools, colleges and visiting local stores and cafes in the centre of Driffield. Relatives played a role in helping people to keep in touch with the community by taking people out shopping, to church or to local attractions.

The service did not have any written visions and values but the 'statement of purpose' and 'service user guide' that it kept up-to-date (documents explaining what the service offered) contained aims and objectives of the service. Staff had access to copies of the service's policies and procedures. They were expected to follow a code of conduct and a dress code and their uniforms were supplied by the registered provider.

The registered manager told us they kept up to date with best practice and legislation via updates from CQC, Healthwatch publications, regular training and health and safety updates from the organisation. They told us they disseminated key information about best practice and any legislative changes to staff in team meetings.

We were told that some staff had completed training in dementia awareness, but when we spoke with them they were unaware of the opportunity to become a 'Dementia Friend' (an Alzheimer's Society initiative to encourage carers and the public in general to learn a little bit more about what it's like to live with dementia and then turn that understanding into action). One staff said they would look into this, as they were very interested in developing dementia care in the service.

The White House Residential Home was registered with the Care Quality Commission in December 2010 and has had no changes to its registration other than a change of manager since that time: a new registered manager was appointed in 2013.

We looked at documents relating to the service's system of monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a regular basis and that satisfaction surveys were issued to people that used the service, relatives and health care professionals.

Audits included checks on window restrictors and security, care plan details, water temperatures at outlets and management of medication systems. A local pharmacy had last completed an external medication audit in June 2015 and the issues that had been identified included the need to ensure items stored in the medication fridge were dated when opened, state on the medication administration record (MAR) sheets the quantity of pain relief tablets issued to people and to record on the back of MAR sheets reasons why any medication was refused. The registered provider's own medication audits showed there had been many months of no issues being identified since that external audit. While there was no information seen regarding audit analysis there were action plan sheets in place to record any action plans required against information gathered that highlighted shortfalls.

A satisfaction survey was last issued in July 2015 and the registered manager received several back from people that used the service, three from social and healthcare professionals and eleven from relatives. The main issues identified in surveys were regarding décor and furnishings and activities. Other comments lifted from surveys included, 'Father recently came to the home and there has been exceptional care, support and dedication to him and myself,' 'Laundry is always clean but is put in the wrong bedrooms,' 'The home could improve activities a bit,' 'There is no communication between key worker and relatives.' Staff felt there had been some improvements made with activities now held in the afternoon.

We were told that improvements made as a result of quality assurance systems were fed back to people by posting a quality assurance report on the service users' notice board. There were some relative and service user satisfaction survey outcomes pinned on the notice board from the July 2015 survey as well. Analysis of these showed that relatives questions covered topics of communication with staff and the manager, care received, staff attitudes, activities and laundry. Overall scores indicated that most people gave scores of between Good and Excellent for all areas. Activities and laundry had some poor scoring but these points had been discussed at staff meetings, according to the feedback information.

Questions on surveys for people that used the service included 'Is your privacy and dignity respected?' – All agreed that is was. 'Do you feel comfortable and safe with your key worker?' – All agreed they did. 'Do you have control and choice over the care you receive?' – All strongly agreed. 'Do staff respect your opinions and views on your care?' – All agreed. This showed one of the ways people were consulted about their opinion of the service.

There were 'resident' meetings held, the latest one having been in January 2016 at which the Christmas food supplied to people and entertainments provided to them were discussed. Previous meetings had been held in October and May 2015.

Records of staff meetings held in February 2016 for all staff and November 2015 for night staff only, showed that topics discussed covered DoLS issues, laundry, infection control, the living wage, entertainments and staffing issues for the February meeting, while the November night staff meeting discussed covering each other on nights, health and safety concerns, and medication training for seniors only.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.

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 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had not carried out regular health and safety risk assessments of the premises (including grounds). This meant that unsafe surfaces to the garden patio area that required improvement had not been identified or acted on without delay.