Medical Resources Worldwide Limited

The White House Nursing Home

Inspection report

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Tel: 01462485852

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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

This inspection was carried out on 09 July 2018 and was unannounced.

The White House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The White House Nursing Home accommodates up to 67 people in one adapted building. At this inspection 59 people were using the service.

The registered manager had recently resigned from their role. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection the service was being managed by the deputy manager (referred to as 'the manager' throughout the report) with the support from clinical colleagues and the previous registered manager. The provider told us that the service was in the process of being sold and consequently decisions about recruiting a registered manager would be taken by the new provider.

At the previous inspection in June 2017 we had identified some areas that required improvement. At this inspection we found that whilst there had been some improvements made the overall quality of the service provided had not improved sufficiently and further work was still needed.

At the inspection in June 2017 we had identified shortfalls in record keeping and that staff meetings were not always effective. We had found that the provider had not routinely assessed the quality of care that people received or how the home was managed and that incidents and accidents occurring in the home had not been robustly managed and reviewed to identify trends or patterns. At this inspection we found that some processes had been introduced to better manage these areas however, further work was needed.

Staff had been trained in how to safeguard people from avoidable harm however, not all staff were confident in their knowledge about how to report concerns to external agencies if needed. People had personal evacuation plans in place for emergencies such as a fire and regular safety checks were completed however, staff demonstrated a mixed understanding what actions they should take in the event of such an emergency. People and their relatives felt that there were not always enough staff deployed to meet their individual needs in a kind, gentle and timely manner. Some further work was needed to ensure the provider's recruitment processes were robust.
People were supported by staff to take their medicines in a safe manner however, we found that the amount of medicines in the home did not always agree with the records maintained.

There were systems in place to help promote infection control. People said they felt safe living at The White House Nursing Home. Potential risks to people's health, well-being or safety had been identified, were

assessed and reviewed regularly to take account of people's changing needs and circumstances. The manager had developed systems to cascade shared learning from incidents around the staff team.

Staff explained to people what was happening and obtained their consent before providing care and support. However, some staff needed further support to better understand the principles of The Mental Capacity Act 2005 (MCA) and best interest processes. Staff members received supervision from line management to support them in their roles but some felt it was not a meaningful or effective process. People and their relatives told us that there were instances where communication with some staff members was difficult. People and their relatives gave mixed feedback about whether their day to day health needs were met in a timely way and if they had access to health care and social care professionals when necessary. People gave mixed feedback about the food provision and we observed that some people did not always receive good support to eat. Assessments had been undertaken to identify where people may be at risk from poor nutrition or hydration which were kept under review and amended in response to any changes in people`s needs.

The environment was appropriate to meet people's needs in that there was sufficient communal space available for people to be able to sit quietly, join in activities or have a meeting in private. However, there was little in the home to support people who may live with dementia. People and their relatives told us that the care and support provided at The White House Nursing Home was appropriate to meet people's needs. Staff received training to support them to be able to care for people safely.

People's dignity, privacy and confidentiality was not always promoted by some of the staff team. People's choices were not always respected in relation to their care and support needs. People, and their relatives, told us they were happy with the staff that provided their care. Staff took appropriate action to help people feel comfortable. Staff had developed positive and caring relationships with people they clearly knew well. Relatives and friends of people who used the service were encouraged to visit at any time and we noted from the visitor's books that there was a regular flow of visitors into the home.

People's care plans were not always sufficiently detailed to guide staff to provide their individual care needs in a consistent way. Care plan reviews were not always meaningful and not always used as an opportunity to further develop people's care plans. Care plans showed that people were asked to think about their wishes in relation to end of life care. People, their relatives and staff gave mixed feedback about the activity provision at the home. Some relatives were not aware that meetings were arranged for them to share their views and opinions about how the service was run. The minutes of these meetings did not evidence that they were effective in bringing about changes in the quality of service people experienced. Concerns and complaints raised by people who used the service or their relatives were appropriately investigated and resolved.

People knew the manager by name and felt that they were approachable with any problems. The manager demonstrated knowledge of the staff they employed and people who used the service. Staff reported that the manager was approachable and that they could talk to them at any time. There were informal meetings held between the manager and the provider to discuss such issues as recruitment, the performance of the service and any matters arising. However, these were not documented so it was not possible to confirm that these meetings served to support the manager in their role.

There were a range of checks undertaken routinely by the manager to help ensure that the service was safe. Satisfaction surveys were distributed annually to people who used the service, their friends and relatives and relevant professionals such as social workers and specialist medical professionals. At this inspection we were advised that quality surveys were being distributed to people at this time.

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:

Staff had been trained in how to safeguard people from avoidable harm however, not all staff were confident about how to report any concerns to external agencies if needed.

People had personal evacuation plans in place for emergencies such as a fire however, staff demonstrated a mixed understanding what actions they should take in the event of such an emergency.

People and their relatives felt that there were not always enough staff deployed to meet people's individual needs in a kind, gentle and timely manner.

The provider had processes in place to help ensure that all staff employed to work at the home were of good character and suitable for the roles they performed. Some further work was needed to ensure the process was robust.

People were supported to take their medicines by staff who had been trained to do so. However, we found that stocks of medicines did not always agree with the records maintained.

The provider had systems in place to help promote infection control.

People told us that they felt safe living at The White House Nursing Home.

Potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances.

The management had developed systems to cascade shared learning from incidents around the staff team.

Is the service effective?

Requires Improvement

The service was not always effective:

Staff needed further support to better understand the principles of The Mental Capacity Act 2005 (MCA) and best interest processes.

Staff received supervision from line management but some felt it was not a meaningful or effective process.

People and their relatives told us that there were instances where communication with some staff members was difficult.

People and their relatives gave mixed feedback about whether they felt that their day to day health needs were met in a timely way and if they had access to health care and social care professionals when necessary.

People gave mixed feedback about the food provision and we noted that some people did not always receive appropriate support to eat.

The environment was appropriate to meet people's needs in that there was sufficient communal space available for people to be able to sit quietly, join in activities or have a meeting in private. However, there was little in the environment to support the needs of people who may live with dementia.

People and their relatives told us that the personal care and support provided at The White House Nursing Home was appropriate to meet people's needs.

Staff received training to support them to be able to care for people safely.

Is the service caring?

Requires Improvement

The service was not always caring:

People's dignity, privacy and confidentiality was not always promoted by the staff team.

People's choices were not always respected in relation to their care and support.

People, and their relatives, told us they were happy with the staff that provided their care.

Staff took appropriate action to help people feel comfortable.

Staff had developed positive and caring relationships with people they clearly knew well.

Relatives and friends of people who used the service were encouraged to visit at any time and we noted from the visitor's books that there was a regular flow of visitors into the home.

Is the service responsive?

Requires Improvement

The service was not always responsive:

People's care plans were not always sufficiently detailed to guide staff to provide their individual care needs in a consistent way. Care plan reviews were not always meaningful and not always used as an opportunity to further develop people's care plans.

People, their relatives and staff gave mixed feedback about the activity provision.

Some relatives were not aware that meetings were held for them to share their views and opinions about how the service was run. The minutes of these meetings did not show that they were effective in bringing about change in the service people experienced.

Concerns and complaints raised by people who used the service or their relatives were appropriately investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the previous inspection of this service in June 2017 we identified shortfalls in record keeping in relation to care plans, staff meetings and quality assurance. At this inspection we found that some further improvements were needed.

Processes had been introduced to better manage incidents and accidents occurring in the home however, further work was needed.

The registered manager had recently resigned and the deputy manager was managing the service on an interim basis. The provider told us the service was in the process of being sold and that the new provider would undertake the appointment of a registered manager once the sale was completed.

People who used the service knew the manager by name and felt that they were approachable with any problems.

Staff told us that the manager was approachable and that they could talk to them at any time.

There were informal meetings held between the manager and the provider to discuss such issues as recruitment, the performance of the service and any matters arising.

There were a range of checks undertaken routinely by the manager to help ensure that the service was safe.

Satisfaction surveys were distributed annually to people who used the service, their friends and relatives and relevant professionals such as social workers and specialist medical professionals.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 09 July 2018 and was unannounced. The inspection was carried out by one inspector, an assistant inspector and two experts by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us in May 2018. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

During the inspection we spoke with eight people who used the service, six staff members, six relatives, one external professional, the manager and the provider. We viewed information relating to four people's care and support. We also reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff had been trained in how to safeguard people from avoidable harm and were able to describe how they would report any concerns within the organisation. Not all staff we spoke with were confident in their knowledge about who to report concerns to outside the provider's organisation such as the local authority safeguarding team. One staff member said they had a duty to report concerns immediately to help protect people against any type of abuse. Information and guidance about how to report concerns together with relevant contact numbers, was displayed throughout the home and was accessible to staff and visitors.

People had personal evacuation plans in place for emergencies such as fire and regular safety checks were completed. The manager gave us clear detail of their expectations of the staff in the event of a fire which involved using evacuation sledges to transfer people to a zone at least two fire doors away from the fire. The manager told us that random fire drills took place monthly at the home however, staff we spoke with demonstrated a mixed understanding what actions they would take in the event of such an emergency. They told us that there had been no evacuation practice undertaken in the home and they demonstrated a limited understanding of equipment to be used to help people who were not independently mobile to evacuate from the home.

We asked people, their relatives and staff if they felt there were enough staff deployed to meet people's needs. Throughout the course of the day we noted that staff appeared to be constantly rushing through their work and that people were still receiving support to wash and prepare for the day at 11:30 am. This meant that they had not been able to join in any morning activities and were only just ready for the day by the time the lunch service started at midday.

Feedback from people who used the service varied. One person told us, "In the daytime answering the buzzer sometimes takes longer. Night time, you do get a response." Another person who used the service told us, "Yes, they come quickly. Night and day." One person said that their care could sometime feel a little 'rough' and they believed this was because staff were rushing. A relative told us, "I would just like to say that today there seems more staff than normal in the lounge usually there is only one staff member and I worry if things got heated between residents or someone wanted the toilet, there is no-one about to watch over them. The activities aren't that great either, but you weigh the good and the bad the important thing is they care for [relative]".

Staff gave us mixed feedback with some saying that they felt they had to rush when delivering personal care. For example one staff member said, "If someone calls in sick then management will try to get cover either agency or ask staff to do an extra shift. Sometimes they are unable. If they can't it would be really busy and there would be tasks I can't complete such as completing documentation and personal care may not be done as expected (for example rushed)." Another staff member said, "It depends on the day. People's needs change. At times we feel like we need more staff, other days I feel relaxed but it doesn't help when staff ring in sick." A further staff member said, "Yes, there are normally enough staff. People phone in sick. Bank staff and sometimes agency staff do provide cover. If we cannot get anyone to cover it depends on the team working that day, each day is different."

The provider had processes in place to help ensure that all staff employed to work at the home were of good character and suitable for the roles they performed at the service. However, we checked the recruitment records of four staff and found that whilst all the required documentation was in place including two written references and criminal record checks further work was needed to help make the process robust. For example, there were copies of documents to confirm that potential staff members identification had been checked but these had not been signed and dated to indicate that the original documents had been seen by whom and when. We also discussed with the provider and manager that it is good practice to follow up written references with a telephone call to confirm they were genuine.

People were supported to take their medicines by staff who had been trained to administer medicines. People told us they received their medicines on time and that pain relief was promptly given when needed. However, a relative of a person who used the service told us, "(Person's) pain comes on very fast and waiting 20 minutes (for medication) seems a long time, then you have to wait for them to work. But they're (staff) doing their best."

We checked a random sample of boxed medicines and found that stocks did not always agree with the records maintained. This meant we could not be confident that these medicines had been administered in line with the prescriber's instructions. An audit of medicines had taken place the night before this inspection. The audit included a physical count of boxed medicines to check that they tallied with records maintained. The audit had not identified the shortfalls we found. When we brought this matter to the attention of the manager he reported that he had already noted something was amiss with the audit and had intended to explore this with the staff member responsible.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons appropriately and the home was clean and generally fresh on the day of our inspection. However, there were one or two areas of the home where malodours lingered throughout the day. We discussed this with the provider and manager who said this was ongoing work and advised that the majority of the flooring in the communal areas had been replaced since the previous inspection.

A person who used the service was in receipt of oxygen therapy. We noted that safety signs were positioned to alert people to this fact. However, oxygen cylinders were stored in the clinical room without any chains or clamps to prevent them from falling over. This posed a potential risk which had not been identified or assessed by the provider or manager. Once this concern was brought to the manager's attention they took immediate action to obtain professional advice and secure the cylinders safely before the end of the inspection.

People told us that they felt safe living at The White House Nursing Home. One person told us, "Oh yes, (It's safe). They (staff) are always looking out for you. It's not home from home, but they do care about you." Another person said, "Yes, oh yes. The staff are all very kind, can't fault them at all." A further person told us, "I feel safe because everybody looks after me, they (staff) will do anything for me. I am on medication and they give it on time, they will stand to make sure I take it, I have never seen any shouting here or people you know the girls (staff) being un-kind, If I did I would tell someone like the boss or that lady there (activity co-ordinator) she would do anything for me." A relative of a person who used the service told us, "Yes, staff make it seem safe. They are polite and friendly."

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for such areas as poor skin integrity, falls and the use of mechanical hoists. These assessments

identified potential risks to people's safety and the detailed the controls in place to mitigate risk.

People who had been assessed as requiring bedrails on their beds to help prevent them falling had protective covers over the rails to reduce the risk of entrapment. We saw that one person did not have a cover on their bedrail and noted that this was their choice and there was a risk assessment in place to support this decision.

We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition.

The management had developed systems to cascade shared learning from incidents around the staff team. For example staff members advised that there were 'take ten' meetings held during the afternoon where these matters were shared and during handover meetings each morning and at team meetings. An example of this was a where a person had sustained repeated falls in one day. Information was shared through the team at the 'take ten' meeting about how the person's mobility and safety needs would be managed.

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).

At the previous inspection of The White House Nursing Home in June 2017 we had found that the service had not always worked within the principles of the MCA. For example, external professionals and relatives had authorised covert administration of medicines however, we had noted that there was not always an accompanying mental capacity assessment or best interest record to evidence that the person lacked capacity to make such a decision for themselves. (Covert administration means that the medicines are administered for people in their food or drink without them knowing.) At this inspection we found there had been some improvements made however a lack of understanding remained around 'best interest' decisions and the processes that needed to be followed in relation to these such as a mental capacity assessment and obtaining external professional support. Staff members used the term 'in people's best interests' without understanding that this was a formal process.

At the previous inspection we had found that power of attorney authorisations (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 we had found that these were not for health and welfare in all examples, but some were for property and financial matters which had meant that people may not always have had their consent obtained lawfully. At this inspection we found that all POA authorities had been reviewed and discussions had taken place with people's relatives about what the different decisions covered and what the boundaries were.

The manager and staff confirmed that there was a programme of staff supervision in place. Staff members said they received supervision but opinions varied as to the quality. For example comments received included, "I do have supervision but not as often as I'd like - I don't feel supported in that way. I feel it is one way, they are reading off a list of questions and tick boxes and I feel that it is rushed (10 to 15 minutes) and held in an inappropriate place (the lounge)." Another staff member said, "I have regular supervision every six to eight weeks and yes I feel that I am being listened to and it is a two-way conversation." We shared this varied feedback with the manager and provider, they indicated surprise at the negative feedback and undertook to look into the matter.

The previous registered manager was a nurse and had provided the nurses with support and supervision appropriate to their role. Subsequent to the inspection visit we received confirmation that the previous registered manager had agreed to continue providing clinical supervision and support for the nursing team on an interim basis until the proposed sale of the service was completed and the new provider was in place.

People and their relatives told us that there were instances where communication with some staff members was difficult. A person who used the service told us, "I can't always understand the staff. They can't always understand me too." They told us that staff did take the time to try to understand, however the difficulty appeared to be around accents and speaking clearly. Even where staff are fluent in English, strong regional or overseas accents may affect an older person's ability to understand, particularly where people may live with dementia, communication difficulties or hearing impairments. We discussed with the provider and manager the importance of ensuring that staff members receive support and training to ensure that their communication skills are adequate. A relative told us, "At the beginning it was very difficult. Better communication was needed all round really."

People and their relatives gave us mixed feedback about whether they felt that their day to day health needs were met in a timely way and if they had access to health care and social care professionals when necessary. One relative said, "The GP does rounds on Tuesdays. The frailty nurse asked for a new medication last week and has sorted out a lot of things. She's very good and calls in regularly now." Another relative said they were confident that the care people received was appropriate to meet their needs. They said their relative had been admitted to the home with a health issue that had been managed effectively by the staff team. The relative said, "I think it is because the good food and the good care [Person] receives here." However, a person who used the service told us, "I asked to see the doctor and the staff member said 'why?' I told her it was about my leg and she said, 'oh, we see about all that'. That went on for six weeks so I wrote to the doctor." The person went on to say that the doctor had amended instructions in relation to the management of the wound as a result and it had cleared in a short while. We noted that appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dieticians, opticians and chiropodists.

People told us that they were not always provided with a good choice of food. For example, one person told us, "Don't know (if there is a choice)." The person's meal was brought into them at this moment, we asked them about the hot dessert arriving at the same time as the main course, and they said, "We've even had the pudding before the main course before now but they've changed the system." Another person told us, "The shepherd's pie is sometimes a bit greasy so I had a salad yesterday. The roast beef the day before was lovely. The food is hot, there's plenty to drink." A further person said, "I'm vegetarian and my meals are done individually so I'm lucky. I write my own menu. The food could be hotter sometimes. The kitchens do try."

People chose where they wanted to eat their meals. Most people opted to eat in the communal dining room, some in the lounge area and some chose to eat in their rooms. During the lunchtime meal served in the communal dining room people were provided with appropriate calm and relaxed support to help them eat and drink. Staff interacted with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be as independent as possible.

People who were cared for in bed did not always receive good support to eat. We noted examples where people had food offered to their mouths by spoon with no interaction from the staff member supporting them. People cared for in bed did not always have their food served to them whilst it was warm and appetising. For example, we saw a staff member carrying trays for two people, they went to one person and supported them to eat their lunch before carrying on to the second person's room to give them their meal. There was a period of 10 to 15 minutes where the food was on the tray waiting to be taken to the second person and could not possibly have still been warm. We shared this feedback with the provider and manager who undertook to explore staff practice in this area.

Assessments had been undertaken to identify where people may be at risk from poor nutrition or hydration.

These assessments were kept under review and amended in response to any changes in people`s needs. For example, a care plan for a person who had lost some weight regularly over a period of time included information about fortified foods the person would be able to eat to help their weight stabilise. Where people had been assessed as being at risk of choking we noted that information was included within the care plans to help keep them safe. For example, a care plan indicated that a person needed to be seated at an angle of 30 to 45 degrees when eating to minimise the risk.

The environment of the home was appropriate to meet people's needs in that there was sufficient communal space available for people to be able to sit quietly, join in activities or have a meeting in private. However, there was little in the home to support people who may live with dementia. For example, signage was not always clear and bold, there was nothing to enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, artwork, soothing music, and planting) to give them cues about where they were and what they could do.

People and their relatives told us that the care and support provided at The White House Nursing Home was appropriate to meet people's needs. One person said, "I have just had the chiropodist not long ago, and now I am bed bound I can't go to the salon but they wash my hair in bed for me." Another person said, "I have no complaints, the doctor comes every week and you can tell the girls if you want to be seen, but they keep an eye on us as well."

People told us, and our observations confirmed that staff explained what was happening and obtained their consent before they provided care and support. A person said, "Oh yes they will always ask you first if they can do anything you know when they undress you and wash you." Another person told us, "They are very respectful they will always ask permission before doing anything."

Staff received training to support them to be able to care for people safely. The manager told us of various training elements that had been undertaken by members of the staff team and those that were planned for the immediate future. This included basic core training such as moving and handling and safeguarding as well as specific training modules such as end of life care and continence awareness.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always promoted. Staff put a notice on people's bedroom doors to indicate when personal care was being provided, to prevent interruption. A person told us, "Yes, they always close the door and the curtains. They always knock and ask permission before doing anything." However, throughout the day we observed staff knocking on people's bedroom doors and entering immediately without waiting a respectful moment or to be invited in. A person who used the service said, "Yes, (privacy) is okay. They do tap on the door and come straight in." On a laundry trolley we noted piles of clean towels ready to be distributed around the home. We saw that the hand towels were frayed and tatty around the edges.

People's confidentiality was not always promoted. Care records were stored in a lockable office on each floor in order to help maintain the dignity and confidentiality of people who used the service. However, on more than one occasion during the course of the inspection we found one of the offices was unlocked when staff were not using it which meant that people's personal and confidential information could be accessed by people not authorised to do so.

People's choices were not always respected in relation to their care and support. For example, a person had been scheduled to have a bath on a Friday but had requested for it to be postponed until the next day so that it coincided with a change of dressings on a wound. The dressing was changed on the Saturday as arranged but staff had not managed to make time to support the person with their bath. This meant that the person had to have a plastic bag taped over the dressing to keep it dry whilst they had their bath on Monday. A person who used the service told us, "I'm waiting for a bath. I'm on a list, I can't have a bath just when I want to."

People, and their relatives, told us they were happy with the staff that provided their care. A person told us, "I get on with them all. I think they are very, very kind." Another person said, "They are very caring (staff) lovely girls and boys they help me get washed. They take their time and have a chat with me, they always knock on my door even if it's open and they will always wear gloves. Nothing is too much trouble for them they will help you with anything you only have to ask them. They know me very well they ask me about my life, and where I worked, they know what I like (person laughed) they know I like a cup of tea and a biscuit."

A relative told us, "I'm here every day. At first it was because I was not confident in the home. Now it's because I choose to." A relative told us, "The key workers' pictures are on the wall (in the resident's room); that's quite nice to know who is involved. [Nurse] is very good, she tells me how [person] has been. It's good to have someone to go to." We saw cards from relatives of people who used the service giving thanks for the care provided. For example, one family had written, "A very big thank you for the lovely care and support you gave [relative]. We have been very blessed to have had our [relative] in such a caring home.

Staff took action to help people feel comfortable. For example, the inspection took place on a very warm day and cooling fans had been deployed in communal areas to help people feel more comfortable and duvets had been replaced by sheets to help people sleep better in the warm nights.

Staff had developed positive and caring relationships with people they clearly knew well. We observed staff interact with people in a warm and caring manner listening to what they had to say and taking action where appropriate. We heard and observed some examples of lovely, kind and caring interaction between staff and the people who used the service. For example, a person in the communal lounge was exhibiting anxiety and becoming stressed. Staff took the time to talk gently with the person and reassure them.

We were given an example where staff had provided caring and personalised support. The staff had enabled two people who used the service to celebrate their diamond wedding anniversaries on separate occasions with their spouses and invited guests at the home. Staff decorated tables for the couples to share celebratory dinners and the chef made special cakes. Staff played music that the couples had listened to in their courting days and from their wedding days. A person who used the service was said to have been smiling all day and their spouses and invited guests thanked the staff team for making special occasions to treasure always.

Relatives and friends of people who used the service were encouraged to visit at any time and we noted from the visitor's books that there was a regular flow of visitors into the home.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always sufficiently detailed to guide staff to provide their individual care needs in a consistent way. People told us that their care needs were met in different ways depending which staff member was attending to them. For example a relative told us, "They (staff) have different ways of doing things. I did ask a couple of times as I'm trying to see how to help [person] myself. Staff seem to deduce how to do things rather than from training." The relative went on to say, "Getting into the wheelchair is done differently. Some staff get [person] to stand and do a 180 degree turn. I would have thought 90 degrees would be better." The care plans did not include this level of detailed guidance for the staff which meant that each staff member provided care in their own way and not necessarily in the manner that the person wanted or needed to maximise their comfort. For another person with complex specific care needs the care plan stated that they liked to have a bed bath once a week or as required and a full body wash on other days. There was no detail in the care plan to guide staff as to how the person liked this care provided and to enable the staff team to deliver consistent care.

Care plans indicated that people who had capacity had been involved with developing their care plan however, relatives said that the service did not routinely involve them with care plan reviews where people did not have capacity. One relative said, "No, no involvement of the family. Someone has visited (person) and tried to fill in a life story type of thing."

People's care plans were reviewed regularly to help ensure they continued to meet people's needs. However, the care plan reviews were not always used as an opportunity to further develop people's care plans. For example, a person lived with a diagnosis of psychosis, depression and anxiety. The person had lived at the home for a considerable period of time but the information to help staff provide their support had not been updated to include ways that they had found to help reassure the person and support them when they were in a low mood. In discussion with the manager it transpired that the nursing staff were responsible for writing people's care plans. However, they were not involved in delivering people's personal care so did not have the intimate detail needed to develop the care plans centred around individual people's needs.

Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home. The information included whether they wished relatives to be with them at this difficult time and which funeral directors were to be contacted but did not include detailed guidance for staff to follow to help ensure people were kept as comfortable and as pain free as possible.

Information posted in the communal hallway indicated that there were a variety of activities scheduled to take place in the home. However, we observed some nail painting and hand massages taking place during the morning and a ball game in the afternoon but nothing to provide engagement for individuals being cared for in bed or who didn't want to play a ball game. The manager and provider reported that the activity team was depleted on this day due to annual leave and sickness and that this was not the normal situation at the home.

Some people and their relatives gave mixed feedback about the activity provision at the home. One person told us, "Yes, there are things going on. We had exercises from a young lad; it was really good. Also a church service, a sing-song. There's a barbecue coming up." Another person told us, "On Friday, apart from the last three weeks, there was an exercise class but it's not going to happen anymore. I'm not sure why. Maybe not enough people were attending; only four or five of us. I read a lot and I knit when it's not so hot. I'm not aware of any other activities." Other people told us they felt there was nothing to do. A relative told us, "There's morning praise (Religious observance). We go out every afternoon. Activities seem to be oriented more towards dementia patients. The music therapist comes in to [person]." A staff member said, "I think the residents are happy, they take them into garden and on outings in our bus. Residents talk positively about their trips." Another staff member said, "There are many activities such as playing with balls, the activity people go into people's rooms to chat and read. Activities are here every day, I think residents are happy."

People were supported to continue with religious observance according to their individual faiths. For example a person had felt insecure and apprehensive on moving into the home and had shared with staff that they had been active in their church prior to moving into the home. The person had been supported to receive Holy Communion in the privacy of their own room and this had increased their confidence so that they now eagerly looked forward to joining others in group worship at the home.

Subsequent to the inspection the manager sent us information about events such as a trip to a local concert and afternoon tea that some people and relatives had enjoyed. People were said to have greatly enjoyed the day and they had been seen to clap, sing and tap their feet to the music.
A local care provider association had invited the home to join a chair based activity programme aimed at falls prevention. Not many people chose to take part but for those who did it had turned out to have a positive therapeutic effect in that they had enjoyed the activity and some had gained confidence to go out into the garden and use stairs more easily. The activity team had encouraged people to spend time in the garden in good weather for activities such as reminiscence, quizzes and pet therapy in the fresh air. As a result a garden project was formed with people volunteering to help grow such things as bedding plants, strawberries and tomatoes.

We asked people and their relatives about meetings held to share their opinions about the service and facilities provided at The White House Nursing Home. A relative said, "I'm not aware of any residents or relatives meetings." A person who used the service said, "No meetings. We have a church service most weeks." We viewed minutes of a relatives and residents meeting held in April 2018 that showed that relatives were encouraged to air their views and these were recorded along with actions needed to address the concerns. For example, people had shared that they were not always happy with the food because the gravy could be greasy and the custard too thick. The newly recruited cook was at the meeting and they were advised that there had been a few complaints regarding the food including vegetables being too hard, food could be served cold and sometimes food was too greasy. To address this matter a member of staff sampled the food every day for quality control purposes and a member of the management team was to request a meal from the kitchen at random intervals to further enhance the quality control in this area. However, as part of this inspection we had concerns raised about greasy food and we saw that some people's food was not delivered to them whilst still warm so we could not be confident that actions put in place to quality assure this area were effective.

Concerns and complaints raised by people who used the service or their relatives were appropriately investigated and resolved. When we asked people who used the service and their relatives if they would be confident to raise any concerns and a person told us, "Well I suppose I would speak to one of the head people in the office." Another person said, "I complained about people wandering in and out of my room

hence the gate but they responded quickly to that. Oh yes I feel confident in complaining, I would tell the senior carer."

We reviewed records of complaints raised with the management team and found that they had been clearly documented with details of any investigation undertaken and the outcome. For example a relative had raised a concern about a missing pair of glasses. A full search had taken place and the glasses were eventually located in another person's room. In order to help in the event that this situation occurred again people's glasses were photographed so that it would be easier to identify them.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had recently resigned from their post and the deputy manager had stepped up to manage the service on an interim basis who is referred to throughout the report as 'manager'. The manager advised us they were currently undertaking a management qualification and they said, "I won't cross the boundaries of clinical practice, I seek support from the previous registered manager or nursing colleagues if needed." After this inspection we received confirmation that the previous registered manager had an agreement with the provider to deliver clinical support for the nursing team two half days per week and to support the manager in clinical matters.

The provider reported that the service was in the process of being sold at this time and that the new provider would undertake the appointment of a registered manager once the sale was completed. Minutes from a relatives meeting held in April 2018 showed that the provider had kept people's relatives up to date regarding the proposed sale of the home. We made contact with the new provider as part of this inspection process who confirmed the proposed purchase of the service.

At the previous inspection of The White House Nursing Home in June 2017 we had identified shortfalls in record keeping. For example, we had 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. At this inspection we found that people's care plans continued to lack the detail required to help ensure people received consistent personal care and individual support.

At the previous inspection we had found that staff meetings were not always effective. There were no standard agenda items such as health and safety, safeguarding, staffing, and areas of good practise included in the meetings and although information about safeguarding concerns had been shared with staff there was no record of discussion about the learning from these issues and how things could have been managed differently. At this inspection we found that some further work was needed. For example, the staff meeting minutes from 30 April 2018 showed that the deputy manager had, '….advised all staff that skin tears have increased'. There was no evidence of discussion around this matter or what actions had been put in place to reduce this trend. Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home. One staff member said, "Staff meetings are held every month and we have the opportunity to express our views. I think everyone is listened to."

At the previous inspection we had found that the provider had not routinely assessed the quality of care that people received or how the home was being managed as part of an effective governance process. At this inspection we found that no changes had been made. The provider continued to regularly visit the home and they brought anything they noted of concern to the attention the manager but this was not a formal recorded process. This meant that the provider did not operate a quality assurance process to satisfy themselves that they were providing people with a safe service to meet their needs.

At the previous inspection we had found that incidents and accidents occurring in the home had not been robustly managed and reviewed to identify trends or patterns. For example to assess if environmental

factors or staffing levels had impacted on the likelihood of people sustaining injuries as a result of accidents in the home. At this inspection we found that staff reported incidents to the nurse in charge of the shift who then in return reported to the manager for them to check that all appropriate actions had been taken. The incident tracker maintained by the manager detailed incidents that had occurred together with actions taken to help prevent recurrence and promote people's safety. However, the tracker was not always accurately maintained in the absence of the manager. For example the incident tracker for June 2018 indicated that nine falls had occurred in the home during the month but the falls tracker indicated that there had been 13 falls. The manager had noted this anomaly and advised us that they intended to review the monthly report to check for accuracy.

Due to the issues found on inspection, and that well led was rated requires improvement as part of the previous inspection, this was a breach of Regulation 17 of the Health and Social care Act (Regulated Activities) Regulations 2014.

People who used the service knew the manager by name and felt that they were approachable with any problems. One person told us, "[Name of manager] has been very good. It's well managed; it's a big job. The carers really care about you; always got time for you." A relative said,
"The manager is [name]. I got a good response to things I've brought to their attention. General things."

The manager demonstrated knowledge of the staff they employed and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships. We saw them interact with people who used the service, relatives and staff in a positive, warm and professional manner.

Staff told us that the manager was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody and always provided them with opportunities for improvement. One staff member said, "I feel the home is run well, it would be even better if we had more staff. The manager seems to be managing things well at the moment." Another staff member said, "I have learnt a lot of things from [manager]. They are a 'by the book manager' and won't cut corners." A further staff member commented, "I do think the home is well-managed because the residents safety is always paramount to everybody. Aside from that the staff are listened to and this affects change which in turn impacts positively on the residents."

The manager told us that the ethos of the service was to promote staff from within where possible which helped to show staff that there was opportunity for career progression. The manager reported that staff had been supported to progress their skills and knowledge by enrolling on nationally recognised courses. Staff had also received training and support from a local care provider association to enable them to become subject matter champions in areas such as nutrition, end of life care, safeguarding and dementia. This meant that there were skilled people amongst the team for staff to go to if they needed advice or guidance.

We reviewed handover information and found that information about people's care or support was documented and handed over to the oncoming staff. The handover forms were pre-printed with people's diagnoses and included information about their health and wellbeing during the shift. For example, the information included people's fluid intake so that staff were aware if any specific support was required in this area.

There were informal meetings held frequently between the manager and the provider to discuss such issues as recruitment, the performance of the service and any matters arising. However, these were not documented so it was not possible to confirm that these meetings served to support the manager in their role.

There were a range of checks undertaken routinely to help ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails, inspection of the call bell system, and fire checks. We noted that where issues had been identified through this system of audits they were passed on to the relevant person to address. The manager advised that they undertook spot visits outside of their normal working hours to provide support for the staff team and to help ensure the service was operating safely.

There were photographs of the providers together with contact telephone numbers displayed in the communal hallway. This showed that the provider was keen to promote transparency and to make themselves available to relatives of people who used the service if they had any concerns.

Satisfaction surveys were distributed annually to people who used the service, their friends and relatives and relevant professionals such as social workers and specialist medical professionals. At this inspection we were advised that quality surveys were being distributed to people at this time.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there was a robust system of governance and oversight in place to ensure people received safe and effective care.