Medical Resources Worldwide Limited

The White House Nursing Home

Inspection report

Gillison Close
Letchworth
Hertfordshire
SG6 1QL
Tel: 01462 485852

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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

Overall summary

The inspection took place on 12 November 2015 and was unannounced. At our last inspection on 8 May 2013, the service was meeting the required standards.

The White House Nursing home is a nursing and residential care home which provides accommodation and personal care for up to 67 older people. At the time of our inspection there were 65 people living at the home. There is a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people

Summary of findings

where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection no applications had been made to the local authority in relation to people who lived at The White House Nursing Home.

People were supported by staff who were kind and caring. However, people's care plans and risk assessments were basic and did not provide staff with the appropriate guidance. Staff were not clear on people's specific needs.

Staff had received training for areas including Safeguarding people from the risk of abuse, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. However, their knowledge on these subjects was limited.

People did not always receive their medicines safely and in accordance with the prescriber's instructions. The nursing staff had responsibility for managing all medicines and maintained the control measures and storage, records and quantities.

People who were living at the service, their relatives and staff spoke highly of the manager. The manager was a visible presence in the home. However, the manager and the provider had not ensured they had kept up to date with changes in requirements.

People were confident to raise concerns with the staff or the manager and were sure they would be dealt with effectively. However, we were unable to assess the effectiveness of the complaints procedure due to limited action plans and internal monitoring systems.

Systems in place for monitoring, assessing, identifying and managing the quality of the service were limited and not robust. For example, except from the nurse's medicines audit, there were no recent audits completed and an action plan for an earlier audit was basic with no completion of tasks recorded.

At this inspection we found the service to be in breach of Regulations 9, 10, 11, 13, 17, and 18 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe.

People did not have appropriate risk assessments in place to ensure their needs were met safely.

Staff did not know how to report allegations of abuse externally.

People's medicines were not always managed safely.

Staff working at the service had undergone a robust recruitment process.

Is the service effective?

Requires Improvement

The service was not effective.

People were not being supported appropriately in regards to their ability to make decisions.

Staff received regular supervision and training. However, training was not assessed for effectiveness and staff were not always knowledgeable in the role.

People enjoyed the food and were supported to eat and drink sufficient amounts.

Is the service caring?

Requires Improvement

The service was not caring.

People were treated with kindness by the manager and most of the staff.

People were not involved in the planning or reviewing of their care.

Privacy was not always promoted throughout the home.

Is the service responsive?

Requires Improvement

The service was not responsive.

People who were living at the service and their relatives were confident to raise concerns and have them dealt with to their satisfaction.

Care plans were prepopulated and not specific to people's individual needs.

Most people were supported to continue with hobbies and interests. However, this did not meet the needs of all people living at the service.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems in place to monitor, identify and manage the quality of the service were limited and ineffective.

Summary of findings

People who were living at the service, their relatives and staff spoke highly of the manager.

The manager and the provider had not ensured they were up to date with changes in requirements.

The White House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

The inspection took place on 12 November 2014 and was unannounced. The inspection team was formed of two inspectors.

Before our inspection we reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We had requested a 'Provider Information Report' (PIR) The PIR is a form that asks the provider to give some information about the service, what the service does well, improvements they plan to make and how they meet the five key questions. However, we did not receive this information.

During the inspection we spoke with eight people who lived at the service, four relatives and visitors, three members of care staff, three nurses, an activity organiser, a housekeeper and the registered manager. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We viewed six people's support plans and five staff files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

Some people who lived at the service at times experienced significant levels of anxiety. There were no robust and clear risk assessments or plans in place to enable staff to support them appropriately. For example, We looked at the care records for a person who had regular incidences of heightened anxiety which put themselves or others at risk of harm. We saw that there were only limited identified and documented triggers to the person's anxiety and very basic guidance for staff or techniques that helped the person feel better. Staff were not clear how to support this person with these complex needs and directed us to the manager.

The manager told us that the person's trigger was the gender of the staff member who provided their care. However, the person's care notes showed that all instances of heightened anxiety involved a staff member with the gender that triggered anxiety. The manager told us that it was not always possible to meet this person's needs in relation to this due to the staffing structure. This meant that the service was not able to consistently meet this person's needs therefore putting them and other people who were living at the service at risk of harm.

We found that several people had bed rails on their beds. Some of the bedrails did not have covers to protect people from entrapment. This meant that people were at risk of getting parts of their body through the gaps in the rails which could result in injury. We noted that people who had bedrails had a risk assessment in place. However, these risk assessments had not been reviewed and therefore may no longer be appropriate to meet individual people's needs.

The manager told us that they did not monitor accidents, incidents and ill health to identify trends or themes. Care plans seen confirmed that these were not reviewed and updated to reflect any actions implemented to reduce risks to people. This meant that there was greater risk of a reoccurrence of an accident or incident that impacted on a person's safety and welfare as steps had not been taken to reduce the risks.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People told us that they felt safe. One person told us, "They protect me." However, one person told us that people [who were living at the service] were going in and out of their room made them feel unsafe. We brought this to the manager's attention. We noted that some people had gates on the door to prevent others walking into their bedroom. We asked two people about this who confirmed that it had been their choice. We observed one of these people exit the gate without assistance.

Staff had received training in relation to safeguarding people from the risk of abuse. There were posters displayed telling people how to report concerns to the local authority. Staff were able to tell us what the types of abuse were and that they would report it to their manager. However, none of the staff were able to tell us how they would report concerns to external agencies. During our inspection we observed a staff member prevent a person from accessing the kitchen by pushing them away by their shoulder. We immediately brought this to the manager's attention. The manager did not respond appropriately. We informed the local authority about the incident immediately following our inspection. This showed that the manager did not have robust systems in place to ensure that allegations of abuse were responded to appropriately.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People did not always receive their medicines safely. Medicines were administered by the nurses on duty. The nurses told us that they were responsible for ordering, dispensing and auditing the medicines. One nurse said, "We monitor it closely and count them every two weeks." We saw a record of regular checking by the nurses. The Medication Administration Records (MAR) were completed consistently and we observed two medicine rounds. However, we were told by the nurses that three people received their medicines covertly. The nursing staff told us that they were administering medicines covertly to three people. They confirmed that there had been no input into this process by the pharmacist or the person's GP. Therefore the nursing staff were unaware if they were mixing the medication with substances that may reduce the efficacy of the medication. There were no risk assessments in place for this method of administration. The nurses did not know of any risks to this method of administration and therefore have put the three people at risk of unsafe medicine administration.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

Requires Improvement

Is the service safe?

We saw that there was a robust recruitment procedure in place and staff files demonstrated that this had been followed. Before commencing employment, staff had undergone the appropriate checks to ensure they were fit to work in a care setting this involved appropriate criminal record checks and written references which had been verified.

People gave mixed views in regards to whether their needs were met promptly. One person told us, "I don't get assistance quickly, sometimes I end up calling and they don't hear me." Another person told us, "They come quickly but I rarely call." Staff were allocated a section of the home for each shift which included a list of people they were responsible for whilst on duty. Staff told us that this worked well and that they worked closely together to ensure that they covered each other's sections whilst unavailable or on a break. Throughout the inspection we saw that people had their support needs met in a timely fashion. A relative told us, "They get help in a reasonable time." This meant that there were sufficient staff to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

We found that three people using the service were receiving medication covertly. This decision had been made without the appropriate mental capacity assessment being in place. Therefore it was not clear whether each person had the capacity to make this decision for themselves. The nursing staff confirmed that there had been no best interest meetings held involving the appropriate e representatives and professionals. The basic capacity assessment had been carried out by staff who were unable to tell us what the MCA 2005 meant. In people's care records it was staff who were listed as responsible for making decisions on behalf of the people. This meant that important decisions about people's health and welfare were being taken by staff who were not appropriately authorised to do so.

The manager told us that there was no one who was living at the service who required a Deprivation of liberty safeguards (DoLS) application. They told us that they did not deprive anyone of their liberty. However, several people had bedrails in place which did restrict their freedom by keeping them in bed. They were not able to express their views regarding the bedrails due to their complex health needs and were unable to give their consent. This had not been assessed or agreed as a best interest's decision. Whilst within the home, we saw that some internal doors were restricted access with a key code and the access numbers were not available for people to use. We asked the manager if they had reviewed their position in regards to people having the freedom to independently exit the building following recent case law. The manager told us that they had not. This meant that the service may have been depriving people of the liberty without a proper assessment and authorisation. Therefore they were not implementing the Mental Capacity Act 2005 appropriately.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People told us that they felt staff were skilled for their role. One person told us that they had recently suffered a fall and staff supported them appropriately.

Staff attended courses such as health and safety, Dementia awareness, safeguarding people from the risk of abuse and MCA 2005. However, we found that some of the training had not been effective. For example, some staff we spoke with were not clear on how to report a safeguarding concern externally and also what their role was in relation to the MCA 2005. The provider and the manager did not ensure that the manager and staff team's knowledge was up to date to ensure they worked in accordance with good practice and current regulations consistently. For example, recent case law relating to DoLS and the MCA 2005. Staff told us, and records confirmed, that they received regular one to one supervision. They told us that they felt supported by their manager.

People told us that they enjoyed the food provided for them. One person told us, "I get my meals in my room, there's a good choice. The food is good and I have plenty to drink." Another person told us, "There's a good choice of food and we can change it if we don't like it." We observed breakfast and lunch time during the inspection. People were offered a choice of balanced and nutritious food. When they refused what they had previously ordered, an alternative was offered and provided. People were supported appropriately with eating and drinking. We observed staff heat up soup for a person who was eating slowly and it had got cold. Some people had drinks in front of them throughout the day. However, we also saw that others, who were unable to get up and get themselves a drink, did not have a drink within reach. Staff told us they were offering drinks to those who couldn't get a drink independently and that they completed fluid record charts. We saw these in people's bedrooms and in the lounges. One person who lived at the service told us, "We all help each other, I go round and get drinks for people sometimes." This meant that staff ensured people received adequate amounts of food and drink to meet their nutritional needs.

People who lived at the service and their relatives told us that their health care needs were met. For example, requests for the GP were made promptly. Medical care notes seen had a record of visits from health and social care professionals. These included their GP, dieticians, mental health professionals and dentists. Staff sought the advice of professionals as needed. There was also a visiting chiropodist and a hairdresser. This meant that the service ensured [people had regular access to health care professionals.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not consistently promoted. We saw that people's bedroom doors were open when they were in bed and one person was visible to visitors and others whilst using their toilet facilities. Staff told this was the usual practice. There was no reference to whether or not people preferred their doors open, in particular while in bed, in people's care plans. People whose doors were open were unable to comment on their preferences due to their complex health needs. We saw people be taken to the toilet one after the other and at set times throughout the day. For example, after breakfast and after lunch. They were not asked if they wanted to go to the toilet they were just taken. People's individual needs in relation to toileting were not reflected in care plans and staff had adopted a routine approach. They were unable to express their preferences to us. This did not respect people's dignity or independence. Staff did tell us that they would, "Close doors when delivering care", "Give people choices" and "Communicate well with people." But we did not see this in practice on the day of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People told us that the staff at the home were mostly kind and caring. However, one person told us, "Not all of them are caring, some are brilliant. I have some people [staff] saying I'm not on your section." We observed staff speak kindly to people throughout the day. However, some staff called to people across rooms rather than going to them and speaking. We also noted that a group of people in two of the lounges received little interaction from staff throughout the day. Relatives of people who lived at the service told us that the relationships between people and staff and relatives and staff were positive. They told us that they were attentive and knew people well. One relative told us. "I can really talk to them."

People who lived at the service and their relatives told us that they were not involved in planning of their care. The manager told us that they were asked for their views. However, through further discussion with people, the staff and the manager demonstrated that staff planned and organised people's care with limited involvement from the person. Records viewed confirmed this. However, relatives did tell us that the staff at the home kept them informed of changes via telephone or on their visits. Relatives told us that they were welcomed into the home and staff were friendly. One relative told us that on the day that their loved one moved into the home, staff had greeted them by name. They told us, "This was lovely, really put me at ease, they obviously knew we were coming."

Requires Improvement

Is the service responsive?

Our findings

People were not involved in the planning or reviewing of their care and told us they had not seen their care plan. One person said, "I don't know if I have a care plan." Another person told us that they were not aware that they had a care plan and, "No one tells me." A relative told us, "No I've not seen it [care plan]." Care plans were not written in a way that demonstrated a person's individuality and did not explain people's specific needs or life history. The information recorded did not provide care staff with guidance in relation people's needs. We saw that when people had regular assistance from the nurses for issues, such as pressure ulcers, this was recorded in short term care plans. However, they did not include a full explanation of what care or support was needed. For example, the frequency in which someone should be repositioned or their required mattress settings. This meant that there was a risk that all staff were not aware of peoples changing care needs.

We saw that when pressure relieving equipment was required it was not always set at the required settings for people's weights. We were told that the maintenance person was responsible for setting the pressure relieving equipment. Staff confirmed that they did not tell the maintenance person what the needs of the person was so they would not be aware of how to set the pressure relieving equipment correctly. The manager told us that mattress checks were not recorded. This meant that people were receiving pressure care that did not meet their needs and increased the risk of them developing a pressure ulcer.

Care staff were not able to be specific about people's individual needs. They told us that guidance was given by the nurses on a day to day basis so that they knew what care needed to be given and how to support people. The nurses were unable to be specific about people's needs and told us that they instructed care staff on what needs to be done during the handover. We asked to see the document used to record the handover and guide all staff on what was needed to ensure people's needs were met. The manager told us that there was not a document. This meant that people were at risk of not receiving the appropriate care to meet their needs as there was no clear guidance for care and nursing staff on how to support people.

This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People told us that they had their needs met. We were told that this was done in a way in which they liked. However, one person told us, "They all do it differently."

The home was in the process of transferring all paper care plans into electronic care plans. We asked the manager how people and their relatives would be involved in the information on these new plans and reviewing them. They told us that relatives could view the information on a portable tablet or go into the office and view the computer. There was currently no facility for them to record their input or to support people to who the plans related and in particular those with complex needs, in accessing the new system.

People who lived at the service and their relatives told us that they were happy to raise concerns with the manager and confident that they would be dealt with. One person told us, "I'd speak to the manager, [manager] is in and out all the time." Another person and a relative told us that they had made a complaint and were satisfied with the response.

The service had a monthly plan of activities scheduled. This included sensory games, arts and crafts, singing, cooking and gardening. During our inspection we saw that group activities were going on in one lounge. However, people who had more complex needs were sitting in other lounges throughout the day with no activities provided. We spoke with one of the two activity organisers who told us that they spilt their time with one doing group activities and the other spending one to one time with people in their rooms. They told us that they spoke with relatives about people's previous hobbies and interests and tried to support this. However, they did not document what activities people had participated in or the frequency.

People's care plans did not state what past interests and hobbies were and they were unable to tell us if the activities provided supported this. We noted that involvement was not reviewed to ensure that people were supported to be engaged and maintain previous interests. This meant that the service were not able to ensure that they were meeting the needs in relation to people's hobbies and interests for all people who lived in the home.

Requires Improvement

Is the service well-led?

Our findings

The service did not ensure systems in place to assess, monitor and manage the quality of the service was to a good standard. Therefore they were unable to ensure that high quality care was delivered as the quality assurance processes and monitoring were not always consistent or effective. For example, audits, surveys and meetings were limited, infrequent and action plans were basic.

The internal quality assurance system had also not identified concerns found during our inspection in relation to risk management, medicines, MCA and safeguarding people from the risk of abuse. In addition, the manager did not monitor and analyse incidents and accidents to reduce risk and identify learning outcomes. This meant that people may be at risk of an incident, accident or avoidable harm as these had not been identified or shared with staff.

We had requested a PIR for the purposes of our inspection. However, the manager was not aware of the requirement to send us this information and we did not receive it.

People who lived at the service, their relatives and staff told us that there were not actively involved in developing the service. We were told that meetings were not held often and there was no sharing of outcomes following them when they were held. One person told us, “I’m not aware of any meetings or surveys.” A relative told us, “No, I’ve not had a survey or aware of any meetings.” A staff member told us, “There are no regular staff meetings, I can’t remember the last one.” There were no other opportunities for people to be involved in providing feedback. This meant that the manager’s systems in place to assess, manage and monitor the quality of the service did not identify and resolve issues that we had identified at the inspection. This may have impacted on the quality of service that people received.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that the manager was always available. Relatives told us that they frequently spoke with the manager. We observed people and their relatives speaking with the manager throughout the day.

The manager told us that they were frequently, “Out on the floor, supporting the staff, helping if they needed help with a resident or advice.” Staff confirmed that this was the case. They spoke highly of the manager. One staff member told us, “[Manager] is very approachable.” Another said, “I think this is a very good care home.” Staff told us that they enjoyed working at the home and they cared about the people they supported. Staff were clear on what the manager expected of them and told us they would go to the manager if they had any questions or concerns. This demonstrated an open culture amongst the staff and manager. Whilst the manager and staff had the outlook that people came first, however, we did not observe leadership that promoted a people first culture.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not ensure that people were protected against the risks associated with inappropriate or unsafe care as they did not operate effective monitoring systems.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person must ensure that people are safeguarded against the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not ensure that people received their medicines safely.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person people's dignity was promoted or ensure people were involved in decision making about their care.**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The service did not make suitable arrangements to obtain and act in accordance with the consent of people in relation to care provided for them.**