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The White House

Inspection report

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Date of inspection visit:
24 September 2020

Date of publication:
11 November 2020

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
The White House is a residential care home providing personal care and support for up to 38 older people. At the time of the inspection there were 16 people living in the service. Most people were living with dementia.

People's experience of using this service
Relatives feedback the management team were approachable and staff were kind and caring and knew people well.

However, we found systems to monitor the quality of the service were not effective as there remain three breaches of regulation. Records were being transferred from paper to an electronic system. Staff handover records had improved but other records, such as care plans were not adequately maintained.

The registered provider continued not to fully mitigate the risks to people's health and safety. People did not have comprehensive care related risk assessments such as for diabetes and catheter care.

Staff did not have comprehensive plans to develop their skills and knowledge. Staff had not always received the training, support and guidance they required to meet people's needs. This included their knowledge in supporting people with dementia, understanding about consent, diabetes and infection control.

Staff gained people's consent before proving care and treatment. However, there was inconsistent understanding of how to implement the MCA 2005. Staff and the provider's had not received training in MCA 2005 to ensure it was applied as the legislation intended.

Improvements had been made in how the service acted in response to complaints. Feedback from relatives was that the provider listened and acted on any concerns they raised.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 4 December 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of three regulations.

Why we inspected
CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned

about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We undertook this targeted inspection to follow up on the six breaches of regulations, identified at our last inspection. The provider had failed to effectively: manage risks; monitor the quality of the service; respond to complaints; provide staff with necessary training for their roles; provide people with personalised care; and to act in accordance with the Mental Capacity Act 2005. A decision was made for us to inspect and examine these risks.

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

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

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

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, identifying and addressing shortfalls in the service provision and staff training, at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

The White House

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the six breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to managing risks; monitoring the quality of the service; responding to complaints; providing staff with necessary training for their roles; providing people with personalised care; and acting in accordance with the Mental Capacity Act 2005.

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

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the service. One inspector was at the service for the day and another for part of the afternoon. A third inspector worked offsite.

Service and service type:
The White House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

One of the providers was also registered with the Care Quality Commission to manage the service. The registered manager and provider were both legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 24 hours' notice of the inspection. This was to establish the safest and most appropriate way of carrying out our inspection visit during the covid-19 pandemic.

What we did before the inspection here
We sought and received feedback from the local authority. We reviewed information we had received about

the service since the last inspection. The providers were not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. The providers sent us the staff training matrix and overview of audits, before the site visit as requested. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with one person who lived in the service and telephoned three relatives to gain feedback about their experiences of using the service. We spoke with six members of staff including the provider, registered manager, senior carer and three care staff.

We reviewed a range of records. This included four people's care notes and plans, accidents and incidents, complaints records, staff training matrix and quality checks and audits.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection of the service the registered provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- There continued to be insufficient information about potential risks to people and how to minimise them. Therefore, staff did not have all the guidance they needed to support people in a safe and consistent way.
- Assessments of risk relate to the individual assessment of a person's health, social and personal care needs. The provider told us they sometimes found it difficult to know which information to include in people's care plans and associated risk assessments.
- One person used a catheter, which was monitored by a district nurse. This is a tube in the bladder for removing fluid. Risks associated with the use of a catheter had not been identified, such as urinary tract infections and blockages. Staff were not aware of the signs and symptoms to look out for which may indicate medical intervention is required.
- Risk assessments for the management of diabetes had now been completed. These included information about people's diet and monitoring of people's blood sugar levels. However, there was no guidance about how to recognise if people had too much or too little sugar in their bodies (hyperglycaemic or hypoglycaemic). Nor what immediate action they should take to keep people safe and healthy. Staff did not understand how to recognise these conditions or how to respond to changes in people's blood sugar levels.
- Some people used emollients to treat dry skin conditions. The provider had not considered the fire risk and taken actions to minimise them. When fabric with dried-on emollient comes into contact with a naked flame, the resulting fire burns quickly and intensely.

We found no evidence people had been harmed, however, failure to robustly assess and manage the risks relating to the health safety and welfare of people is a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Feedback from relatives was staff made their loved ones feel safe. One person told us, "X had a fall and fractured their hip. We discussed their care plan and safety things like an alarm mat. We worked together towards this."

Learning lessons when things go wrong
At our last inspection of the service the registered provider had not recorded actions taken when things go wrong. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There continued to be inconsistency in identifying and addressing safety concerns such as accidents and incidents.
● The providers said they made a record of all accidents and incidents at the service and reviewed this record monthly to identify any patterns or trends. However, not all accidents and incidents had been analysed so action could be taken to minimise any reoccurrence.
● Staff had recorded in the accident book that one person had fallen three times in September 2020. However, the provider's monitoring record only showed they had fallen once in September 2020. The provider was not aware this person had had multiple falls so they could take action to prevent further falls and make improvements. Their care plan had not been updated to reflect this change, nor had this change been discussed with the staff team. The providers said they would discuss the person's falls with their GP.
● Another person had sustained a bruise to the right side of their face at the end of August 2020. Their care notes indicated they may have knocked their head on the wall or bed rail. This accident had not been included in the provider's monthly review so they were aware of the incident. The way service user D was cared for in bed had not been reassessed to see if anything could be done to minimise the risk of them hurting themselves in the future.

The registered provider had not recorded actions taken when things go wrong. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● 11 out of 13 staff had undertaken infection control training. No staff had completed covid-19 specific infection control training and 1 staff had not completed training on how to take on and off their PPE safely. We saw staff wearing appropriate PPE during the inspection and this was confirmed by feedback from relatives. However, the providers could not be assured staff had the knowledge and skills to minimise infections during the pandemic.
● The service was clean and free from unpleasant odours on the day of the inspection.
● The service was participating in a national program to ensure staff and people living at the service were regularly accessed tested for covid-19. People were not admitted to the service until they received a negative covid-19 test result.
● There was a procedure for visitors to follow which required them to book in advance, to reduce the number of visitors at any one time.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last inspection of the service the registered provider had failed to provide appropriate up to date training for staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff training and development continued to not fully take into consideration people's care and support needs. The providers explained the planned programme of staff training had been disrupted due to the pandemic. However, they were not able to provide any evidence of any training which had been planned or rebooked for the staff team.
● Most staff had completed infection control training, but this had not been updated to include the impact of the pandemic. This is despite CQC sending the providers a link about how to access online covid-19 infection control training.
● The service provided care for four people with type two diabetes. People with type two diabetes, develop diabetes during their lives. However,the training matrix did not include training in diabetes. Staff did not know how to recognise the signs and symptoms if people were hyperglycaemic or hypoglycaemic. The provider told us staff would ring them if they were not sure what to do. This does not ensure staff have the skills and knowledge to effectively respond to people's assessed needs.
● The training matrix did not include providing staff with training in the Mental Capacity Act 2005. It is essential that staff understand the principles of the legislation so people can make or be supported in the best way, to make decisions. There was inconsistency in staff confidence and knowledge about how to put these principles into practice. The service is registered to provide care and support for people living with dementia. This training is therefore essential in ensuring the effective delivery of care to people who live in the service.

Failure to provide appropriate up to date training for staff is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most staff had undertaking training in safeguarding and knew how to recognise and report any concerns so action could be taken to keep people safe.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection of the service the registered provider had failed to act in accordance with the Mental Capacity Act 2005 This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11. However, staff understanding of applying the principles of MCA 2005 were inconsistent and we have raised this shortfall above in staff training.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Since the last inspection, the providers had consulted and sought advice from the local authority DoLS office. The providers had reapplied for DoLS authorisations which were time limited, to make sure any restrictions were lawful. However, staff did not always know who had a DoLS and how it affected their care and support.
- Mental capacity assessments had been undertaken for less complex decisions, such as if people could consent to what to eat or receiving personal care. However, staff did not always understand how to follow this guidance to ensure decisions, made for people who had been assessed as lacking capacity, were made in their best interests.
- The providers had not undertaken training in MCA 2005 in order to ensure they gave the correct advice and guidance to the staff team.

Inspected but not rated

Is the service responsive?

Our findings

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

At the last inspection this key question was rated requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

At our last inspection of the service the provider had failed to provide care in a person-centred care manner that meets people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- Improvements had been made to care plans, to guide staff how to care for each person in an individual way. However, further improvements were required to ensure consistency.
- It had been identified at the last inspection that there was insufficient guidance about how to support people with diabetes. This had been partially addressed and we have raised this shortfall in the Safe domain with regards to managing risks.
- Staff explained how they successfully distracted a person who could become anxious to prevent any physical or verbal aggression escalating. However, this person's care plan had had not been reviewed for seven months, since February 2020. This information had not been added to their care plan to guide all staff, together with any situations that could trigger the person's behaviours.
- Care plans contained individualised information about people which was important to them, such as their past history, likes and dislikes. Staff were guided how a person's dementia affected their ability to communicate and their long- or short-term memory.

Improving care quality in response to complaints or concerns

At our last inspection of the service the provider had failed to act on a complaint received. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

- The provider was working towards recommendations made by the local authority as a result of a complaint they had received. This included updating people's family contacts and ensuring the management of falls.
- The provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The policy included information about other organisations that could be approached if someone wished to raise a concern outside of the service such as the social services and the local government ombudsman.
- Relatives told us they did not have any complaints about the service. One relative told us, "They do listen,

for example I complained about mum's washing and they sorted it out."

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key questions at the next comprehensive inspection of the service. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

At our last inspection of the service the provider had failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and failure to ensure records were accurate, complete and consistent. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems to monitor and improve the quality of the service continued to be ineffective. Breaches of regulation identified at the last inspection had not been fully addressed. These relate to managing risks, and making sure staff have relevant training and written guidance to follow, to meet people's individual needs.
- There continued to be inconsistency in analysing accidents and incidents to reduce the impact on people of these events reoccurring. The providers audits had not included all accidents and incidents such as one person repeatedly falling and another person bruising the side of their head.
- Plans to address shortfalls in the service provision were not adequate. After the last inspection, the providers sent us an action plan detailing that staff would receive training in safeguarding, dementia, mental capacity and medicines by April 2020. The providers explained this planned training programme had been disrupted due to the pandemic. However, they were not able to provide any evidence that these trainings had been rebooked for the staff team.
- Records continued not to be adequately maintained. There was an inconsistency in care planning records. Some had essential guidance missing. Although a person using a catheter had not had an infection, there was no information available about how to recognise if they did have an infection and how to help prevent this from occurring. The provider told us this information was available at the service and went to look for it. However, they were not able to locate it. Some care plans were not up to date. For example, one person's care plan had not been reviewed for seven months, since February 2020. This meant people's care needs might not be met because of poor record keeping.

The failure to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and failure to ensure records were accurate, complete and consistent is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The management of the service was shared between the two providers, one of whom was the registered manager. The registered manager was present at the service daily. The other provider was in regular contact with staff and reviewed computer records.

● Staff and relatives were positive about the management of the service. They said the providers were approachable and supportive. All relatives said they would recommend the service to others. Comments included, "I do feel the service is well managed. Their main focus is the residents"; and "I would recommend it. I like the size of the home."

● Staff understood an important aspect of their role was getting to know people well. Relatives were complimentary about the kindness of staff and this was reflected in our observations. Comments included, "The carers are good. They work very hard"; and "Staff do, do their best. Everything is fine. I am quite happy. Staff are friendly."

● There had been improvements in sharing information about people's care and support at daily staff handovers. One of the providers often led these meetings to help ensure changes to people's health and welfare were discussed and recorded.

● The provider had informed us of significant events that had occurred at the service. It is important that the Care Quality Commission (CQC) has a clear overview of all incidents at the service, so we can check that the provider has taken appropriate action.

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 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide appropriate up to date training for staff. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not fully mitigated the risks to people's health and safety. Regulation 12(1)(2)(a)(b)

The enforcement action we took:

not yet known

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not recorded actions taken when things go wrong. The registered provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and failure to ensure records were accurate, complete and consistent. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

not yet known