White Horse Care Ltd

WhiteHorse Care - Brownhills

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Whitehorse Care Brownhills is a residential care home providing personal care to eight people at the time of the inspection, seven of those people had a learning disability or autism. The service can support up to eight people.

People's experience of using this service and what we found.
The service was not able to demonstrate they were meeting the underpinning principles of right support, right care, right culture.

Right Support
There were ongoing incidents between people using the service and staff had not received training from the provider in order to support people when they became distressed. The home's communal area was noisy and busy in the mornings and late afternoon onwards. This atmosphere was not conducive to people who disliked noise. Risk assessments were not clear and did not provide guidance to staff on how to meet peoples' support needs. There were not enough meaningful activities to engage people. One relative said, "They [people] need to get out more. It doesn't happen now. It hasn't happened for a long time." Another relative said, "There is not much in the way of activity."

Right Care
People were not supported by staff who knew them well and understood their needs. Staff on the day of inspection were either new or agency. There had been a high turnover of staff. Not having regular staff was having a negative impact on people. One relative told us, "[Name of person] was very distressed. This is normally down to a change or not used to the people [staff]. There has been a lot of upheaval. There have been a few incidents with [name of person] and other residents."

Right culture
The new provider had not made enough improvements to improve the quality of care for people. The provider had not identified or addressed the root cause of why there were continuing incidents between people using the service in order to ensure people were safe and free to live from abuse.
They had not been able to maintain either a stable management team or stable staff team.

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

Rating at last inspection
This service was registered with us on 23 September 2021 this is the first inspection.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. The provider had changed the name of their legal entity and registered as a new company. This means they now are registered as a new service and we needed to inspect and rate the service. The inspection was prompted in part due to concerns received about safe care and treatment and staffing. A decision was made for us to inspect and examine those 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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

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 safe care and treatment, staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

WhiteHorse Care - Brownhills

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 two inspectors.

Service and service type
Whitehorse Care Brownhills is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The current manager had applied for registration.

Notice of inspection
This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider had not been asked to complete a provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and three relatives about their experience of the care provided. We spoke with six members of staff including the manager, operations manager, senior care staff and care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Staffing and recruitment

- There was a high turnover of management and staff which meant people were not being supported by staff who knew them well. All relatives we spoke with told us how people's anxiety was heightened which led to an increase in distressed behaviours.
- Staff who were supporting people during the inspection had not received any training from the provider in how to support people who were experiencing distressed behaviours.
- There was a continued number of incidents between people at the service. Whilst the provider had raised safeguarding concerns, there was no evidence of what action was being taken to reduce the number of incidents that were taking place.
- We asked the manager for some analysis of incidents during the inspection, they told us they were unable to provide this. We could, therefore, not be assured of people's ongoing safety and right to live free from abuse at the service. Therefore, people continued to be at risk from abuse and unsafe care.
- One relative told us, "[Name of person] was very distressed. This is normally down to a change or not used to the people [staff]. There has been a lot of upheaval. There have been a few incidents with [name of person] and other residents."
- Another relative told us, "It [the service] lurches from one crisis to the next. We have lost all faith in the service."
- Staff we spoke to were able to tell us what action they would take if they were concerned for a person's safety. However, the provider's own audits had identified there was a gap in some staff's knowledge around safeguarding and training was being arranged.
- There were recruitment processes in place and recruitment checks were carried out before staff were appointed. There were some gaps in employment history which the management team had identified in recent audits and were working to address.

Assessing risk, safety monitoring and management

- Risk assessments at the service were not updated and lacked sufficient information to guide staff on how to support peoples' needs safely. For example, there was no risk assessment in place or information for staff regarding how to support someone with a catheter.
- One person's risk assessment stated they were not to be left alone whilst eating food due to a risk of choking. We observed this person being left alone to eat on the day of inspection. We addressed this with the manager who had already identified this and had spoken to staff.
- We observed another person being transferred unsafely on the day of the inspection. There was not enough detail in the risk assessment to inform staff how to safely transfer the person. We brought this to the manager's attention on the day of inspection who told us they were agency staff. It is the responsibility of the provider to ensure all staff whether agency or permanent have the correct skills to support people safely.

Using medicines safely

● Improvement was required in the way peoples' medicines were being managed.

● We found the temperatures for the fridge which was used to store medicines was too warm at 9.5 degrees and staff had not been consistently recording daily temperatures. The provider's medicines policy dated May 2020 stated, "The temperature should be maintained at 2 – 8 degrees centigrade and monitored and recorded twice daily." When medicines are stored at incorrect temperatures, this can alter the effectiveness of the medicine. The manager told us they would order a new fridge immediately.

● Some medicines were stored in the office which had no ventilation and was very warm. There were no temperature checks in place to ensure these medicines were being stored at the correct temperature. The provider's medicines policy states, "The ambient temperature of the drugs storage room should be maintained at or below 25 degrees centigrade and monitored and recorded daily as a minimum. As no temperature checks were being made, the provider had not ensured the medicines were being stored at the correct temperatures.

● Some medicines were stored in a trolley which was left in the main communal lounge. Trolleys that are used to store medicines should be secured in order to ensure medicines ares kept safe. The medicines trolley in the lounge was not secured. The provider's medicines policy stated, "Where medicines are stored in a locked trolley, this should be securely fastened to a wall when not in use." The provider had not, therefore, followed their own policy.

● We observed where some PRN medicine ("as required") which had been used recently, had not been transferred on an up to date medication administration record (MAR). The provider had not ensured themselves whether this medicine was still needed or being used.

● PRN protocols to guide staff for as required medicine were generally in place. However, we identified one PRN medicine which did not have a protocol in place.

● We observed a risk assessment which stated PRN medicine was in place for a person with a choking risk. Staff were not aware of this and it was unclear if this medicine should be used. The manager told us they would make the appropriate referrals to clarify this.

● There were no competency checks recorded on staff who administered medicines to ensure they were working in line with best practice and administering medicines safely.

Preventing and controlling infection

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Infection control training had not been reviewed and updated to make sure staff were aware of the latest government guidance.

The provider's failure to have robust systems in place to ensure people received safe care and treatment was a breach of a Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safe Care and Treatment.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. Due to the size and layout of the home, it would be difficult for people to socially distance in the event of an outbreak.

● We were somewhat assured that the provider was using PPE effectively and safely. Staff were seen to be wearing their PPE however, there were occasions where their face masks were worn under their noses and chins.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Clinical waste bins were not in place around the home and PPE was being disposed of in communal areas. There were improvements to be made in the laundry area to make sure people's freshly laundered clothes were stored separately and safely to avoid any cross contamination.

● We were somewhat assured that the provider's infection prevention and control policy (IPC) was up to date. The provider had COVID-19 risk assessments in place for people living at the home but had not implemented COVID-19 risk assessments for the staff working at the home.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the home.
● We were assured that the provider was accessing testing for people living in the home and staff.
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● There are ongoing incidents between people using the service. There was an incident on the morning of the inspection and a further incident the following day. There was no evidence of learning or analysis from these incidents to try to reduce the reoccurrence of them in the future.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience

- Staff who were supporting people on the day of inspection were either new, agency or had not received any training from the provider. This meant people were not being supported by staff who knew them well. It is especially important for people with a learning disability or autism to have continuity of staff to enable them to build trusting relationships.
- Some permanent staff had not received any training from the provider. This meant the provider had not ensured all their permanent staff had the relevant skills and knowledge to support people safely. The new manager was aware of this and told us they were currently arranging training for all staff.
- The new manager told us they had observed staff and stated she they were assured they were competent. However, they told us, they had not completed any formal checks. We identified areas of poor practice or lack of knowledge during the inspection and we could not, therefore, the provider had not ensured staff had the relevant skills or experience to support people safely.
- There was no evidence staff had recently received any supervisions from management. One staff member told us, "I have had no competency checks and no supervisions. The provider's own audits had identified supervisions had not been completed. The provider had not ensured staff were working in line with best practice and had the skills and competencies to support people safely.

Failure to ensure staff were suitably qualified, competent and experienced to enable them to meet the needs of the people using the service at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Staffing.

- The new manager had ensured new staff working on the day of inspection were completing an induction programme.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink. Where people had a specialised diet, staff were aware of this, however, they had not followed the person's risk assessment to ensure they were supervised whilst eating.
- We found food in the fridge which had been opened but no dates had been recorded. We also found food that had gone out of date and we addressed this with the provider.
- Recent concerns had been raised which suggested there was not enough food or variety of food for people to eat. One staff member told us, "There was always a shortage of food." On the day of inspection, we

observed there was plenty of food and fresh fruit and vegetables for people to eat. One person told us, "The food is alright. I get a choice of food."
● People were supported to be independent and cook for themselves where they were able.

Adapting service, design, decoration to meet people's needs
● The building was an adapted bungalow which had been extended to provide people with their own bedrooms. There was only one communal area which contained the lounge, dining area and kitchen. We observed this area to be noisy and busy, particularly in the mornings and later in the day when people returned from day centres. Out of the four care plans we reviewed it was stated that three of those people did not like noise. The one communal area meant it was difficult for people to enjoy the quiet that was important to them unless they stayed in their bedrooms. One relative told us, "[Name of person] can't cope with the noise. It does seem overpowering." A staff member said, "It can be noisy during the day." The operations manager told us they were looking to see how they could make the space more usable to people to support their individual needs.
● Some improvements had been made to the decoration of the building, but the building was mainly tired and in need of updating. The new manager told us they were aware of this and were making plans to improve the decoration with peoples' input.
● There was a garden to the rear of the properly which we were told people liked to use. This was also a little tired and we observed a bin bag which had been left out in the garden area. One relative told us, "The car park and garden definitely needs improvement and the rooms need updating."

Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare in the community and advice was sought from health professionals in order to provide people with the support they needed.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.
Care homes
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.
● The provider was working withing the principles of the MCA and where a person was being deprived of their liberty the appropriate authorisations were in place or being sought.
● There were mental capacity assessments in peoples' care plans and evidence of best interest decisions in order to support people where they lacked capacity to make certain decisions.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- Due to the high turnover of both management and staff, people's wellbeing had been negatively impacted. One relative said, "I think it is making [name of person] uptight. [Name of person] gets uptight very quick. It happens quite frequently."
- Interaction we observed from the staff was mixed. We observed periods of time where both people and staff were sitting around with no interaction at all other than to ask if people would like a drink. We observed one person shouting out who was ignored by staff.
- We observed some good interactions between staff and people where they were engaged in meaningful conversation.
- We observed a music activity which one person, in particular, enjoyed. However, this activity was noisy and people that did not like noise were also in the same communal area. This meant that the activity was not person centred to all people in the area. We also observed staff doing craft activities with one person.
- Relatives we spoke with told us there was not enough activities to engage people. One relative said, "They [people] need to get out more. It doesn't happen now, it hasn't happened for a long time." Another relative said, "There is not much in the way of activity."

Supporting people to express their views and be involved in making decisions about their care
- The new manager had recently held a residents meeting to gain the views of people using the service.
- The manager was working on a new scheme for people to share their views and ideas. They were creating "I said, we did" to evidence where people had expressed their views or ideas, and the management team had taken action.

Respecting and promoting people's privacy, dignity and independence
- Peoples' privacy and dignity were respected.
- Staff did not always use suitable language when talking to people. For example, referring to one person as "good girl". Whilst staff intentions were kind, it was not appropriate to refer to an adult in this way.
- People were supported to maintain their independence. We observed one person who was able to help prepare their own food and drink which they had not previously been able to do.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans and risk assessments were personalised however, they did not contain sufficient information to guide staff on how to support people safely.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The new manager was aware of the Accessible Information Standard and people had communication passports in their care plans. This contained information on their preferred method of communication.

● We observed one staff member use sign language to a person using the service who communicated in this way.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Overall feedback from the recent resident's meeting and feedback from relatives we spoke with, was that people did not get to go out enough and this is something they would like to do more of.

● Some people using the service attended day centres. We observed one person chatting happily about their day when they returned. Another person who had been distressed in the morning seemed a lot happier when they returned from the day centre.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy in place which detailed how to make a formal complaint. Relatives knew who to complain to if they had any concerns.

● There was mixed feedback from relatives about the new manager. Some told us the new manager had contacted them to reassure them about their concerns for the home and what actions they planned to take to improve the service whilst one relative told us they had not heard from the new manager at all.

● Staff told us they felt comfortable to raise concerns with the new manager. One staff member told us, "I had an issue the other night which I raised with [name of manager] and they sorted it, they rang me the next morning."

End of life care and support

● There was no-one receiving end of life care during the inspection. The new manager told us they were intending to introduce end of life care plans for people who wished to discuss their end of life wishes.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The newly registered provider was aware of the improvements that were needed to be made following previous inspections at the service and reassured us they would make the changes needed to improve the quality of the service when they took over registration. Despite the provider sending in regular action plans and receiving support from the local authority, there had not been enough learning and improvement made to improve the quality of care people received.
- Admission processes had not given sufficient consideration to the environment being suitable to meet peoples' needs. For example, one person was due to move from the service as the service was not suitable to meet this individual's needs.
- The provider has been unable to provide a stable management and staff team and there had been a high turnover of both management and staff. All relatives we spoke with were concerned about the negative impact this has had on people using the service.
- The provider's oversight of the service had not ensured risk assessments were updated and contained sufficient information to guide staff on how to support peoples' needs safely.
- The provider's oversight of the service had not ensured medicines were always managed safely, in line with best practice and complying with their own medicines policy.
- The provider's oversight of the service had not identified where infection control training had not been reviewed and updated to make sure staff were aware of the latest government guidance.
- There was a continued number of incidents between people using the service and the provider had not identified or addressed the root cause of the problem in order to improve how people using the service interacted with each other and ensure people remained safe.
- The provider's oversight of the service had not identified where staff had not received any training from them in order to ensure they had the right skills and experience to meet peoples' needs.
- The provider's oversight of the service had not identified where regular supervisions or competency checks on staff had not been completed and recorded in order to ensure staff were working in line with best practice.
- The new manager's audits of the service were mixed. Some had identified where improvements needed to be made whilst others had not identified some of the areas of concern found during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had not completed any recent surveys to gain feedback about the service from people or residents.

The provider's failure to ensure that effective systems were in place to monitor and oversee the quality of the service was a breach of a Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good governance.

● There was currently no registered manager in place as legally required. The current manager told us they were applying for registration.
● The new manager had recently held a residents' meeting to gain their view of the service. The outcome of this was people using the service wanted more activities.
● Staff told us the new manager had held staff meetings to listen to feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The new manager was open and honest with us during the inspection and acknowledged the work needed to improve the quality of the service. They told us they were committed to staying and working to make the improvements needed.

Working in partnership with others
●The service worked in partnership with hospital consultants, social workers, health professionals and relatives in order to support people's needs.

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 provider's failure to have robust systems in place to ensure people received safe care and treatment was a breach of a Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safe Care and Treatment

The enforcement action we took:

We met with the provider and asked them to provide an action plan of the improvements that were needed to be made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's failure to ensure that effective systems were in place to monitor and oversee the quality of the service was a breach of a Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good governance.

The enforcement action we took:

We met with the provider and asked them to provide action plans of the improvements that needed to be made

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff were suitably qualified, competent and experienced to enable them to meet the needs of the people using the service at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Staffing.

The enforcement action we took:

We met with the provider and asked them to provide an action plan of the improvements that were needed to be made.