ARTI Care Homes (South West) Limited

Whitehaven Care Home

Inspection report

Fosseway
Midsomer Norton
Radstock
Avon
BA3 4AU

Tel: 01761413143

Date of inspection visit:
15 January 2018

Date of publication:
01 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 January 2018 and was unannounced.

Whitehaven Care Home is a care home situated in Midsomer Norton near Radstock, which is registered to accommodate up to 23 people. The service is provided by ARTI Care Homes (South West). Accommodation was provided on both the ground and first floor. The service had a communal lounge and dining area and accessible secure gardens.

At the time of our inspection, there was a registered manager in post. 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 2008 and associated Regulations about how the service is run. The registered manager was also registered at another service owned by the provider.

This was the first inspection undertaken since the service was taken over by ARTI Care Homes (South West) Limited

We looked at systems in place to ensure people received their medicines in a safe way. We found staff who administered medicines were appropriately trained to do so. However, we found some concerns with the storage and recording of medicines administered.

We looked at care plans and found they lacked a person centred approach or sufficient information to make sure staff were given the most up to date information. People's interests and preferences were not always identified and recorded.

The provider had a system in place to monitor the quality and safety of the service. However, these were not effective enough to identify the failings or improvements required.

The basic principles of the Mental Capacity Act 2005 had been followed to ensure people's rights were upheld. Deprivation of Liberty Safeguards applications had been made and the registered manager kept these under review.

We observed staff interacting with people and found there were enough staff to meet people's needs. The service had a safe recruitment system in place. Staff received an induction when they commenced employment at the service. This included shadowing other staff so they could get to know the people who lived at the home.

People told us they felt safe living at the home. Staff were confident they could approach the registered manager with any safeguarding concerns and that their concerns would be addressed. There were enough

staff available who had been suitably recruited to help protect people living at the home. Staff told us they had received sufficient training and felt supported in their role. Some people were living with dementia and were supported by staff who had some knowledge of how to support people living with this condition.

People told us they felt cared for and were happy with the support they received from the staff team. Staff enjoyed working with the people who lived at the home and knew people's preferences for how their care needs were to be met. Individual interactions with staff were kind and compassionate; people consistently receive a caring service.

People were treated with dignity and respect and wherever possible people were encouraged to retain their independence.

People had the opportunity to partake in some activities in the home based on their interests. People who lived at the home and their relatives were encouraged to share their opinions about the quality of the service.

We saw that the provider had a system in place for dealing with people's concerns and complaints. People and their relatives said they knew how to raise any concerns and most were confident that these would be taken seriously and looked into.

People who used the service, their relatives and staff, were complementary about the registered manager and felt the management team were approachable.

We identified breaches of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

People's medicines were not always stored safely and we found some omissions in the recording of medicines administration.

People lived in a home that was clean and attractively decorated.

People were cared for by staff who were confident of using safeguarding procedures in order to protect people from harm.

Recruitment processes were effective and protected people who used the service from the risk of unsuitable staff.

People's needs were met by sufficient numbers of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care plans were not person centred or sufficiently detailed.

There were records of best interest decisions being made where people lacked the mental capacity to make informed decisions about their care.

People were always offered a choice of food and drink

People were cared for by staff who were suitably qualified and knowledgeable. They were supported by the manager through regular supervision and appraisal.

People were supported to maintain good health and had access to appropriate services, which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff had time to listen to people, answer their questions, provide information, and involved them in decisions about their care.

Staff respected people's privacy and supported them to ensure their dignity and independence was maintained.

Staff responded promptly, with compassion and kindness when people experienced physical pain and discomfort or emotional distress.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care; however, records did not reflect the care being given.

People were not always asked about their end of life wishes

People were supported to be involved in activities; some people told us that they would like more to do.

People knew how to complain and felt that any concerns would be dealt with immediately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the service delivery were not always effective. Issues we raised as part of this inspection had not always been identified and/or addressed effectively.

People and their relatives had the opportunity to voice their opinions about the service and contribute their suggestions.

People who used the service, their relatives and staff, were complimentary about the registered manager and felt they were approachable.

Whitehaven Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 January 2018 and was unannounced. It was carried out by two adult social care inspectors and an expert by experience who spoke with people and relatives. Our expert by experience had knowledge and understanding of residential services or caring for someone who uses this type of care services.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at notifications received by CQC. A notification is information about important events, which the provider is required to tell us about by law, like a death or serious injury.

We looked around areas of the service, and talked with 11 people who lived at the service about their care. Conversations took place in people's rooms, with verbal consent and in the main communal areas.

We reviewed records including four care plans and risk assessments. We looked at a range of other records, staff rotas, medicines records and quality assurance surveys and audits. We talked with two relatives who were visiting their loved one, the registered manager, four care staff and a visiting health professional.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. There was a process in place for checking the medicine administration records (MARs) twice a week to ensure all medicines had been signed for; however, this system was not effective because we saw nine signature gaps in MARs. Despite this, staff had signed the check sheet to confirm there were no gaps. We pointed this out to the registered manager, who had conducted audits of the charts, as had the provider in their monthly audit visits and neither of them had discovered these omissions.

Some entries on the MARs had been transcribed incorrectly by staff. It is good practise for staff to sign these and for another staff member to check the entry for accuracy. We saw six transcribed entries, none of which had been signed or countersigned. Two of the entries of a medicine for hypothyroidism had been transcribed incorrectly because the dose written was in grams rather than micrograms. This meant there was a risk that staff could administer an overdose of the medicine to the person. Another person had been prescribed an anti-anxiety medicine. The printed instructions on the MAR were "half a tablet twice a day for agitation". There was a handwritten note at the front of this person's chart stating, "To have Lorazepam at breakfast, lunch, tea and bed from now on". Although this note was signed, it had not been dated and the dose to be given was not stated. The MAR chart had not been amended. Staff had been administering the medicine four times a day since 2 January 2018. In this person's notes, dated 02/01/2018, it had been documented "GP rang and will review him later in the week but if we need to give (person's name) another Lorazepam during the day we can". This entry contradicted the handwritten note at the front of the MAR and did not identify any dose prescribed by the GP.

Medicines were not always stored safely. Although the majority of medicines were kept in a locked room, fridge items were not. The fridge was in another room. The door to this room was kept open all day and the fridge was unlocked. Controlled medicines were stored safely and regular stock checks were undertaken. The temperature of the medicines room and the fridge were monitored. However, the fridge temperature had often been recorded incorrectly. Instead of 5 degrees centigrade for example, staff had occasionally documented 0.5. The registered manager said this was a mistake, but there was nothing documented on the monitoring chart to show that staff had realised that 0.5 was not within the required range of temperature or that this had been escalated. The medicines room had no ventilation. The monitoring chart showed that the temperature regularly reached 25 degrees, which is the maximum recommended temperature for the safe storage of medicines. There was nothing documented to indicate that staff had identified that the temperature was high or that they had taken any action (such as using a fan) to bring the temperature down.

Some people had been prescribed transdermal patches. Manufacturer guidance specifies that the site of these patches should be rotated to avoid skin irritation. There were no patch records in place and staff had not documented on the MAR where they had applied the patches. It was therefore difficult to assess if the patch locations were rotated or not.

Some people had been prescribed additional medicines such as pain relief on a PRN (as required) basis. It is

good practise to have protocols in place for the use of these so that staff know when people might require them and the reasons why. There were no protocols in place.

Medicines for disposal were not managed safely. We saw a locked drawer where medicines for disposal were stored, but they had not yet been entered into the disposal book. This meant staff could not be sure that the amounts for disposal were accurate or not.

Although the provider had medicines policies in place, these were not being followed by staff. The medicine administration factsheet informed staff to sign the MAR immediately when medicines were administered. The medication to be taken as required referred to the use of "specific plan for administration recorded in the service users care plan ad kept with their MAR charts".

We saw that some people went out for the day with friends or relatives. In these instances, staff gave the medicines people were due to the person taking them out. The provider's policy stated that in these cases the designated person outside the home would sign to accept their responsibilities. On the day of our inspection one person was going out with a visitor. Staff gave the visitor the medicines to be administered, but did not ask them to sign anything. After the inspection the registered manager informed us that the provider's policy is usually followed by signing the reverse of the MAR sheet.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager who told us they would amend their audits and recheck all entries to identify any errors. Following the inspection, we received an action plan from the registered manager telling us how they were going to do this.

Although care plans contained body maps which staff had completed if any injuries or bruising to people were noted, it was not clear how these were investigated or whether further action was taken. For example, in one person's plan it was documented on admission that bruising had been found on the person's thighs. This was documented on 11 December 2017 however there was nothing else documented to show whether the reason for the bruising had been explored or reported externally. We spoke with the registered manager about this and they immediately sent the commission a notification in retrospect.

All the people who were able and relatives we spoke with told us they were safe living in Whitehaven Care Home. Comments included "So much more than I did at home", "Oh yes very much so", "I would describe it as safe here, yes", "Of course no worries in that department" and "Yes I do feel extremely safe living here". Statements from relatives included; "Tremendously safe, I don't believe anything bad can happen to her here" and "From what I have seen completely safe".

The provider had policies in place for safeguarding vulnerable adults and whistleblowing. These contained guidance on the action that would be taken in response to any concerns. Staff had been provided with safeguarding training. Staff told us, "I would document it and report it straight to the Senior". Staff were familiar with the term "whistleblowing" and knew how to report concerns in relation to poor care, including contacting the commission.

Care plans contained risk assessments for areas such as falls, skin integrity and malnutrition. However, when risks were identified, the plans did not always provide enough guidance for staff on how to reduce the risks. For example, one person had been assessed as being a high risk of falling, but the care plan guidance was limited to "Uses a stick but sometimes forgets to use it. Make sure he has his stick with him at all times". In

another person's plan it had been documented "Can mobilise independently, but is sometimes unsteady", however the guidance for staff was limited to "Monitor and assist when needed". We spoke with the registered manager about this and they assured us that they would rectify this straight away. Following the inspection, we received an action plan detailing the actions the registered manager had put in place.

There were enough staff on duty to meet people's needs. People told us, "There is always someone around if I need them" and "We did bring up in the residents meeting one more member of staff would be nice but apart from that it's not bad". Staff were visible throughout the day and staff spoke positively about the staffing levels. Comments included "I think there is enough, yes" and "Yes we have enough staff". One health professional said, "I've never known them to be short staffed and the staff never appear to be stressed". When asked about staffing levels, relatives told us "I would say yes, always feels like there is someone around". Staff told us that they covered holidays and absences between themselves, as consistency was the key to good care. The registered manager stated that the home did not use any agency staff and we saw rotas, which reflected this and demonstrated that there were always sufficient staff to care for people.

People who were physically able, were free to move around the home unimpeded. Where a person's physical mobility was difficult, we observed staff sensitively supporting the person to move around the home at their own pace, using relevant aids and adaptations. This meant that people using the service were all treated with dignity and respect regardless of their individual abilities.

Safe staff recruitment and selection systems were in place and followed to make sure suitable staff were employed to work at the home. All applicants completed an application form, which recorded their employment and training history. Each applicant went through a selection process. The provider ensured that the relevant checks were carried out to ensure staff were suitable to work with vulnerable adults. The provider requested criminal records checks through the Government's Disclosure and Barring Service (DBS) as part of the recruitment process. The DBS helps employers ensure people they recruit are suitable to work with vulnerable people who use care and support services.

The home had an emergency file that contained peoples' next of kin contact details and staff contact numbers. This detailed planning ensured that in the event of an emergency, people would be evacuated and looked after correctly.

The provider had an infection control policy, which was in date, with review dates set. These policy review dates helped ensure that the policy contained current best practice guidelines. The policy identified the values, principles and procedures to be followed by staff. We saw a cleaning schedule that had been developed. We saw signs for effective hand washing in all the bathroom/toilet areas and appropriate personal protective equipment available for staff.

People told us "They clean constantly, never see any mess anywhere", "I am very mobile still and I have never had any problems with falling over while being here", "Always clean and tidy yes" and "No smells no mess nothing, it is very lovely" and relatives stated "Always, always clean and tidy"
and "Yes very clean environment."

All parts of the building were well maintained and the environment was warm, clean and clutter free. They were systems in place to make sure the environment was safe for people that used the service. The registered manager had completed a workplace risk assessment and fire risk assessment and they reflected current risks at the service. The maintenance person carried out safety checks. These included regular checks of room temperatures and water temperatures.

We saw that all incidents and accidents were recorded and investigated by the registered manager. We saw that they were investigated and actions taken for example referral to the falls or SALT Team .Audits were then completed on a three monthly basis.

Requires Improvement

Is the service effective?

Our findings

Plans in relation to people's nutritional needs were limited. For example, we looked at the plan for one person who was having a fortified diet due to weight loss. The guidance for staff was limited to "needs encouragement to eat and drink". The person's food and drink preferences were not documented and there was no guidance for staff on how to ensure the person had a fortified diet, such as the use of full fat milk and cream. Another person had diabetes, which was managed by diet. The plan for this person guided staff to "Keep an eye on what he's eating and offer him diabetic food". Again, the person's food and drink preferences had not been documented and there was no guidance for staff on what a "diabetic diet" was.

In one person's plan it had been documented the person was "border line diabetic". The guidance for staff was to "offer a healthy and varied diet", but there was nothing written to explain what this meant. In the daily notes for this person staff had documented on 12/11/2018 that the person had gained weight, but there was no reference made to the kinds of food the person had been offered or encouraged to eat in order to lose weight. Some people were having their food and fluid intake monitored. Although the monitoring was up to date and it was easy to see how much people had received there were no target intakes documented. This meant that although staff could see clearly how much people had had to drink, it was unclear how they would know if the total intake were sufficient or not. All of the fluid monitoring charts we looked at showed that generally people's fluid intake had been good.

Food monitoring charts lacked enough detail for staff to assess accurately whether people had eaten enough, or what they had actually eaten. Details of the meal provided were documented, but staff had then documented "half eaten" for example and had not detailed which part(s) of the meal the person had received. This meant it was difficult for staff to assess whether people had received a nutritionally balanced intake each day.

This lack of detail was discussed with the registered manager and again we noted that neither the registered managers' nor the providers' audits had identified these omissions.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mental health and cognition care plans had limited detail. In one person's plan, it had been documented "unable to make everyday decisions" and "staff to keep reminding (person's name) of daily activities and events". This did not show that staff had fully assessed the person's mental health needs.

Consent to care and treatment was not always sought in line with legislation and guidance. None of the care plans we looked at contained mental capacity assessments, despite it being documented in some people's plans "Lacks capacity". 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. Following the inspection, the registered manager informed us that they had found this paperwork and provided information, which showed best interest meetings were held.

Some people had passive infrared (PIR) systems in their bedrooms. These are used to alert staff when people move around in order to reduce the risk of people falling. However, there was no evidence in people's plans that their capacity to consent to the use of the PIRs had been assessed. Additionally, when people lacked capacity to consent there was no evidence of best interest decisions being made There was nothing documented in care plans in relation to whether people had active Lasting Power of Attorneys in place. We discussed this with the registered manager during our inspection in relation to one person's PIR, where the person lacked capacity to consent. They said the person's son had consented to its use, but there was no evidence of a best interest decision meeting. We found there were no records of best interest decisions being made where people lacked the mental capacity to make informed decisions about their care. Following the inspection, the registered manager informed us that they had found this paperwork and provided information, which showed best interest meetings were held.

Despite this, we heard that staff asked people for their consent prior to assisting them. We heard staff saying, "We're going to have lunch now. Do you want to come through to the dining room?" and "It's up to you- you can stay here if you want to". On one occasion we heard staff assisting a person with a clothes protector. Although they did not specifically ask the person if they wanted a clothes protector, this was done in a caring way. They said, "let me put this on, then you won't get your dinner down you".

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). People's freedom had been restricted to keep them safe. We were told that two people were subject to a DoLS and others had been applied for and were currently with the local authority awaiting a decision. We discussed how people with capacity could leave the home as the front door was locked. The registered manager told us that people could ask to leave the home and they would be given the code to leave and if necessary staff would accompany them, if they were assessed as unsafe to walk by themselves. We noted that most people were too frail to leave unaccompanied and went out with family or staff.

Staff told us about their understanding of mental capacity. One member of staff said; "The MCA is where everyone has capacity until proven otherwise. We observe, and talk to residents and this is very clear in their care plan. We have a daily routine. I do understand about DoLS." Another told us; "We do assume that residents have capacity and we do ask for their opinion. We have had training on the MCA but I can't recall everything to mind at the moment. We do have residents that have DoLS."

People were happy with the choice of food and drink. In the morning, people were offered a choice of coffee or tea. People said; "Anytime you want a drink or something to eat, they make it for you." We observed the lunchtime meal in the dining room and also in a side room. People told us "If you don't like what you're given you can always send it back and have something else" and "Oh yes lots of different things every day." We saw everyone was given choice. People we observed did not appear to need any assistance with their food, however there were staff available if anyone required anything.

Staff we spoke with told us they welcomed the training they received and felt it helped them to better support people and understand their requirements. Staff said their most recent training was mental

capacity training. The training gave staff sufficient knowledge and insight into people's needs and this included a range of courses. For example, dementia care, falls awareness, management training, nutrition and hydration, creating therapeutic relationships, distressed behaviour, person centred care, team working, promoting healthy skin, dignity awareness, equality and diversity and mental capacity. All staff had the opportunity to study for a Diploma in Health and Social Care, previously known as the National Vocational Qualification (NVQ).

Staff told us, and their training files showed they received regular supervision from the registered manager, to discuss their work performance and training needs. Staff members' comments included, "I have supervision every two months or more if I need it" and "[Name] does my supervision." Staff told us they were well supported to carry out their caring role. Staff said they could approach the registered manager at any time to discuss any issues. They received an annual appraisal to review their progress and work performance. Staff told us communication at hando6vers was effective to keep them up to date with people's changing needs.

People had access to ongoing healthcare. Records showed that people were reviewed by the GP, the district nurse and the mental health team for example. Records showed people were supported to attend hospital appointments. One visiting health professional said, "The staff contact us with any concerns immediately and will be really proactive. For example, if they're worried about someone's pressure areas, they might ask us to come and have a look, but when we get here they will already have put a pressure relieving cushion in place".

There was equipment to help people stand and to move around the home, when it was needed. People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms, which they were able to personalise with their choice of paint and wallpaper, their own belongings and possessions. This helped to ensure and promote a sense of comfort and familiarity. People told us; "The rooms are lovely and clean and the beds." "We can bring in our own ornaments and things." People could choose to spend time in any of the three communal areas or their rooms. The home had an accessible garden to the back of the property.

Good

Is the service caring?

Our findings

Staff had developed caring, meaningful relationships with people. People consistently told us they were supported in their day-to-day care by staff who were kind and gentle. People told us they were happy living at Whitehaven Care Home. One person told us, "The staff here are wonderful, I could not ask for nicer carers", another stated, "it feels like my home here" (its) "Very very caring". The registered manager had cultivated an inclusive atmosphere in the home where people, relatives and staff shared a mutual respect and affection. Relatives consistently praised staff who had worked at the home for a long time for their caring attitude. When asked what made the staff 'special' one person told us, "They talk to me like one of their own".

A commonly recurring theme from conversations with people and their families was how the attentive, caring nature of the staff made them feel their wellbeing mattered to them. Staff spoke positively about their roles. Comments included "I love working here. We really get to know the residents and I'm very fond of them all", "Residents have a good relationship with the staff", and "Care is good here. We do everything we can for people". One said, "It's very homely here. It's like a big family "and "I know it's my job, but we treat people with care". One visiting health professional said, "I think its brilliant here. Care is always of a high standard".

People appeared well cared for. They looked well kept, their hair was groomed and fingernails were clean. They wore clothing that reflected their age, gender and previous life style and footwear was appropriate. We were told by staff and relatives that if people had an accident with any food or drink, staff would discretely take them back to their room and change them into clean clothes. This meant people were supported to maintain their dignity.

We observed people being supported during lunchtime in a kind and caring manner. Those people who required assistance with eating their meal were supported at a pace appropriate to them. Staff chatted with people, shared jokes and sang along with people. Staff were attentive and encouraging of those people who were reluctant to eat. Staff checked to see how the person was feeling and offered alternative meals or snacks. Staff asked if people needed support and sought permission before offering assistance. Care plans did not always describe people's likes, dislikes, and their preferences but we found staff knew personal preferences and they demonstrated their knowledge when asked.

People consistently told us that staff treated them with dignity and respect, which we observed when staff supported people in their day-to-day lives. They told us "I don't really need much help, but if I do need help they ask me and are very polite about the whole thing" and "They always knock my door". We asked relatives if they felt their loved ones privacy and dignity were respected in the home, they stated "I believe so, I have never doubted otherwise" and "Yes as far as I have seen".

People responded to staff with smiles or by touching them, which showed people were comfortable and relaxed in their company. When required, staff spoke slowly and clearly, allowing people time to understand what was happening and to make decisions. When people were upset, we observed that staff recognised

and responded appropriately to their needs immediately, with kindness and compassion. Staff were skilled at supporting people with sensory impairments. They knelt in front of visually or aurally impaired people, to establish good eye contact to make themselves seen and heard Staff knew people's life stories, their interests, likes and dislikes, which enabled staff to engage in conversations about topics other than the person's, support needs. Staff had completed relevant training and understood their responsibilities in relation to equality and diversity.

Staff had completed training and demonstrated knowledge in relation to their responsibility to maintain the confidentiality of people's care records in order to protect their privacy. Staff told us about the importance of treating people's personal information confidentially. During our inspection all care records at the home, held on computer, were kept securely to ensure they were only accessible by those authorised to view them. However, the paper copies, though not the complete record, were not always held securely. We reminded the registered manager to remind staff to always lock the door of the room in which these were held.

Requires Improvement

Is the service responsive?

Our findings

The service used electronic care plans. We found that care plans did not always have details about people's choices and preferences in relation to how they wanted to receive their care. This meant the provider relied on staff remembering information and passing it on to new staff. Personal life histories were not always completed although when we asked staff about people, they knew their life stories. Care plans did not always demonstrate that people's physical, mental health and social needs had been holistically assessed. For example, plans in relation to people's mental health needs were limited. In one plan it was documented the person had "early stage dementia, can become upset at times" but the guidance for staff was limited to "Monitor, document any changes. Lots of TLC to be given when this happens". There was nothing documented to show that staff had identified why the person was getting upset, whether this was related to their dementia or not, what the signs of being upset were and nothing to explain what "TLC" (tender loving care) actually meant in practice.

There were no plans in place in relation to people's social or spiritual needs. However, the registered manager told us that they had been trying to arrange for a local church minister to come to the home to conduct services and one person living at the home went out to church services with staff support.

Care plans about people's personal care needs were sometimes task focussed and included statements such as "needs support to make sure clothes are on the right way and they match" and "dress in comfortable clothes". There was no detail about what people preferred to wear or what "comfortable" meant, or whether they liked to use specific toiletries. Preferred routines, such as the time people liked to get up or go to bed were not documented. However, we did see in one care plan that staff had documented the person liked to dress smartly and wear jewellery. Plans in relation to people's sleep routines were varied. For example, in one plan it had been written that the person could become agitated at night and unsettled. But the guidance for staff was "meds trained staff sometimes give him a tablet to calm him down and that helps him to sleep". There was nothing to inform staff of any other techniques they could use before resorting to the use of medication to help the person settle and sleep. In another plan it had been documented that when the person woke in the night staff should give "TLC and cup of tea and she will go back to sleep" but TLC was not defined. However, in another person's plan it had been written, "Offer tea and biscuits before bed as this helps her settle".

Some of the language used in plans was not professional. For example, the use of the phrase "TLC", "pinny" (when referring to skin folds), "likes to wander", "to be toileted regularly" and "legs need to be creamed". Although care plan reviews had been completed on a monthly basis, it was not clear how often people were invited to participate in these. Additionally sometimes the information documented was conflicting. For example, the review for one person stated the person had not been invited to take part, but beneath this it had been documented that the person refused to take part.

Staff understood the basic principles of person centred care and when we discussed people with staff they knew a considerable amount about their needs and choices. However, this information was not consistently documented which meant there was a risk that staff who were new might not be aware of how people

wanted to receive their care. One staff member said, "We need more information in the care plans. I don't think all staff read them". Staff were not always able to show us where information was recorded about people's choices and preferences, as it was not always available. In the plan for one person there was a reference made to the person getting "frustrated". There was no guidance for staff on how manage and support the person when they felt like this. However, during the inspection we observed this happening and the staff member assisted the person calmly and quietly. They assisted the person and we observed they immediately became more relaxed. A visiting health professional said, "The staff here know the residents really well".

There were no advanced care plans in place. These plans enable staff to know about people's preferences for their end of life care, such as any religious requests or whether they wanted to die at the home or elsewhere.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about this and following the inspection, they organised training on person centred care planning and end of life planning.

Staff had a handover at the change of each shift to keep up to date with any changes. Staff used electronic tablets to record the care and support they gave to people; people were usually present when this was completed so they would be involved. When we asked people if they were involved in their care planning, comments were mixed 'All the time, it's lovely to have someone to chat to', 'Yes they do always chatting away to me about everything' and 'No they never come talk to me'

People were supported to maintain relationships with people who were important to them. Relatives and visitors told us they were able to visit whenever they wanted and were always made to feel welcome. One person told us "My relative lives in Spain so I don't think I can go see him". Following the inspection, the registered manager told us that they were going to provide training in order for people to use the homes' electronic tablets to Skype their loved ones, especially those who lived abroad.

People told us they would like more activities, one person told us, "We do some things, but I wish there was more of it." Another person told us, "It's a bit sleepy here not much going on" however, "We do get to go out on trips, to Weston super Mare and places like that, which I enjoy very much." The registered manager told us that staff provided activities during the day. There were various posters around the service to inform people of entertainers that would be coming in. During the inspection, we saw staff doing an exercise class with people and one to one time with people who did not want to take part. Staff told us they enjoyed doing the exercise class and did it every morning to motivate people to move about. The registered manager told us they were looking at the provision of activities within the service to improve what they could offer, including more trips out by combining activities with the providers other home.The service had just started using staff as Ambassadors in place for each person living at Whitehaven who will take ensure that all people have time to do things that they enjoy, such as go for lunch. The registered manager told us that it was up to the person what they wanted to do with their time with their Ambassador.

Concerns and complaints were investigated in line with the provider's policy. There had been no recent written complaints. People and relatives told us that they knew how to complain if they needed to. There was information about how to complain in each person's room and in the main reception. People told us they were able to speak to the registered manager and staff if they had any complaints.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes in place had not been effective in identifying the shortfalls found at this inspection. The registered provider had systems in place to monitor the quality of the service. The registered manager completed several audits such as medication, infection control, staffing, building and premises, and health and safety. We found that the audit process had not always identified concerns we raised as part of this inspection. For example, the medication audit had not identified shortfalls in recording. We noted that although there were audits in place the monitor the quality of the care plans, they had failed to identify what we had found. The provider had failed to maintain accurate and complete record in respect of each service user. . Particularly where 'no change' had been recorded each month and had not identified changes in people's care. The care plans we looked at on this inspection still required work to ensure they were person centred. Food and fluid charts were lacking in detail and some meals were not recorded. This meant that shortfalls in the service were not being identified and appropriate actions taken. The registered manager and deputy manager responded to the shortfalls we identified and put actions in place to remedy these following our inspection. However, the systems in place had not identified them. This meant people were at increased risk of receiving poor quality care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, there was a registered manager in post who was supported by two senior care staff. We spoke with people who used the service and their relatives about the leadership and management of the home. They were happy with the service they received at Whitehaven Care Home. One person said, "She seems very nice, but I have not sat and had a chat with her." Another person said, "She is very nice but I see her rarely." Although relatives spoke highly of the registered manager, one told us "'Yes she seems very nice, talked to her a few times, but I have noticed she is very busy".

There was a management structure in place and staff were aware of their roles and responsibilities. Senior staff supported the registered manager, as they were also the registered manager of the another of the providers' homes and they split their time evenly between both homes. Staff spoke positively about management and the culture within the service. Staff told us they were happy with the way the service was managed, felt the service was well led and said, "The manager is very accessible", "If the manager isn't in, we can go to any senior staff member with a concern or issue" and, "We can raise issues or concerns without fear of consequences."

Staff told us that they were reminded in team meetings of the provider's vision and values, which were, "To give care I would expect my family to receive; safe, person-centred care and maintain their independence." Staff were aware of the values of the service and told us, " This place is homely" and "It's very friendly." Staff told us the service was, "A good place to work."

People and their relatives were invited to meetings to discuss the home and to voice their opinions and

suggestions. People who lived at the home told us they were absolutely confident and sure that their thoughts and ideas were acted upon. They told us "Oh yes we have one quite often, I always attend, but you don't have to if you don't want to" and "We do yes, it's nice because we get our say and can air anything that has been niggling us." Another person stated "We have them regularly, we talk about what's coming up, what we like having for meals; things like that"; "Indeed we do, I don't usually go, but I know I can if I want to." The registered manager created a mini action plan from the minutes of the meetings and published these in a monthly newsletter.

Surveys had been conducted twice a year to gain feedback from people and their relatives about the service they received; and from staff about their experiences of working at the service. Responses from the surveys in July 2017 and December 2017 had been quite low so the registered manager explained that they had rewritten the surveys to try to get more people to take part. The registered manager explained that the responses from December 2017 were with the provider but showed us that previous surveys had been collated and analysed in order to identify any areas, which needed change or improvement.

We spoke with staff who felt supported by the management team. One said, "I think we have a great staff team. We help each other and pull together." Another said, "The management make it clear that residents come first." They also stated morale was "really good, we all get on really well". One said "I can go home and know that I've supported people and that people are happy" Staff confirmed and records clearly identified that regular staff meetings were taking place. Documentation confirmed the names of attendees along with topics and actions taken as a result of the meeting. The registered manager said, " I listen to what staff have to say and often implement their ideas and make sure I recognise their contribution." Staff we spoke with confirmed that staff ideas were applied in the home." It was evident that the management team valued the staff and respected their input and commitment.

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 9 HSCA RA Regulations 2014 Person-centred care care plans were not person centred and did not contain relevant information about people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment peoples medicines were not safe, gaps in MAR charts, unsafe storage

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance audits were not effective