Platinex Limited

Whitewaves Care Home

Inspection report

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Tel: 01243601557

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Whitewaves Care Home on the 22 October 2017. This was an unannounced focused inspection.

Whitewaves Care Home provides support and accommodation for 19 older people, some of whom were living with dementia. Nursing Care is not provided. The home provides accommodation over three floors with a passenger lift and stair lift available to access all floors. The premises are located close to the seafront and amenities of Selsey West Sussex. At the time of our visit there were ten people living at the home.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At an inspection in April 2016 we found five breaches of regulations. This was because the provider failed to assess and keep up to date the risks to the health and safety of service users and failed to ensure the safe management of medicines. The provider had also failed to act in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had not ensured that people were consulted or involved in planning their care or in the reviews of their care and treatment. The provider had also failed to notify the Care Quality Commission of events that affected the health, safety and welfare of people and had not operated systems and processes effectively to ensure good governance. We asked the provider to take action and the provider sent us an action plan In June 2016 which told us what action they would be taking. We undertook an inspection in April 2017 and found that improvements had been made and the regulations previously in breach were now met. However further development and embedding was needed once new people came to live at Whitewaves. The overall rating for Whitewaves Care Home was Requires Improvement.

After that inspection we received new information of concern in relation to people's safety, staffing levels and the communication breakdown between the service provider and the local authority and visiting health professionals. As a result of these concerns we undertook a focused inspection 22 October 2017 to ensure that people were safe. This report only covers our findings in relation to the safe question and the well-led question. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitewaves Care Home on our website at www.cqc.org.uk

Before the inspection we received concerns from health professionals and local authority in respect of the behaviours of the registered manager who is also the registered provider. These concerns were being investigated by the Local Authority. At this time working relationships were difficult and if not resolved will impact on the running of the home and potentially impact on the health and well-being of people who lived at Whitewaves Care Home. The Local Authority were considering what action they were going to take if the situation was not resolved.

Whilst quality assurance systems were in place, we found that actions undertaken to improve were not always documented or recorded and therefore were difficult for the provider to monitor and take forward. We also found that statements in the audit were not always supported by thorough analysis.

There were systems in place to manage medicines safely however there was a lack of protocols to support the safe giving of 'as required'(PRN) medicines such as pain relief.

Improvements were needed to ensure that care delivery was supported by risk assessments that ensured that people's health needs were monitored and acted on when needed. We found some peoples' recorded weights indicated substantial weight loss over the past six months and no action had been taken or advice sought from health professionals.

People told us they felt safe in the home. Staff were knowledgeable about safeguarding policies and how to recognise different types of abuse. The service ensured risks to people were identified and action taken to reduce risk, for example risk of falls and weight loss. Routine health and safety checks were undertaken covering areas associated with fire safety, health and safety and servicing. The service had contingency plans in the event of an emergency evacuation. Staff and records indicated that fire training and testing was undertaking regularly. People were protected, as far as possible, by a safe recruitment system. Staff had been checked to ensure they were suitable before starting work in the service. There were sufficient staff at this time to meet peoples' needs. People felt comfortable with staff and said, "Great staff, caring with a sense of humour." There was laughter and banter between people and the staff. We also saw some positive interaction between staff and the people they supported.

The provider had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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

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

Whitewaves Care home was not consistently safe. Whilst risks related to people's support needs and the environment had been assessed,
not all risks identified to peoples health had been responded to.

Medicines were stored, administered and disposed of safely. However improvements were needed to be made to the 'as required' medicines.

Staff had received training on how to safeguard people and were clear on how to respond to any allegation or suspicion of abuse.

There were enough staff on duty to meet the needs of people. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

People told us they were happy living in the home and relatives felt people were safe.

Is the service well-led?

Requires Improvement

Whitewaves Care Home was not consistently well led. There was a potential of risk to people because systems for monitoring quality were not effective. Management had not always ensured that the delivery of care was person focused.

Communication with health and social care professionals was not open and transparent at this time.

The home had a vision and values statement and the staff and management team are committed to improve the service.

Whitewaves Care Home

Detailed findings

Background to this inspection

We carried out this focussed 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.

This focussed inspection took place on the 22 October 2017 in response to concerns about people's safety. This visit was unannounced, which meant the provider and staff did not know we were coming. Two inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home, including previous inspection reports, action plans and the provider's information return (PIR). We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and complaints which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed care in the communal areas. We spoke with people and staff, and observed how people were supported during their lunch.

We spent time looking at records, including four people's care records, three staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We spoke with five people who lived at the service, two relatives, four care staff, the deputy manager, the registered provider who is also the registered manager.

We 'pathway tracked' four of the people who lived at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt Whitewaves Care Home provided a safe place for people to live. One person told us, "I am safe here because everyone's kind and friendly." One relative told us, "Absolutely my Mum is safe because they are a very caring bunch of people who look after her." Another relative told us, "Yes I think it's safe because staff are particularly good with my relative and when I visit I can see they are safe." Despite people's positive comments, we found areas of care that needed to be improved to ensure consistent good care.

Whilst there were systems to manage medicines safely there was a lack of protocols to support the giving of 'as required'(PRN) medicines such as pain relief. We identified that for one person they were on a prescribed pain relief tablet (brufen) in the morning but were also having regular PRN pain relief tablets (co-codamol). The medicine administration record chart identified that the PRN co-codamol had been given at the same time as the brufen. A PRN protocol would have identified that they should not be having these two pain relief tablets together due to the fact that they both contain paracetamol. The administrator made immediate changes to ensure that this would not happen again and would inform the persons GP. Staff had not recorded the reasons for administering the pain relief or whether it had been effective to relive the pain. This was an area that required improvement.

Risk assessment specific to each person's needs had been completed, with guidance for staff to follow to provide appropriate support and care. These included mobility and moving and handling, risk of falls, communication, behaviour, eating and drinking, sleeping and waterlow scores, for the risk of pressure sores. Staff monitored for weight loss and weight gain. People's weight was monitored by measuring the length and width of peoples' arms as most were unable to stand on weighing scales. There were inconsistencies in measurements which suggested significant weight loss for certain people. Records for other people identified variable weights for example one person in June 2017 weighed 57.2 kgs and in October 2017 weighed 49.2 kgs, this meant a weight loss of 8 kgs (1.3 stone). These discrepancies had not been identified or acted on by staff. Further checks had not been undertaken. During the inspection process the deputy manager confirmed that peoples' weights had been taken forward as a priority to be re-weighed or measured and referred to the GP if required. This was an area that required improvement.

Staff told us the risk assessments were specific to each person, which meant they were all different. They said the guidance was very clear for them to follow to support people safely. For example, one person's mobility needs had changed and there was evidence that staff continued to encourage independence whilst offering assistance when required.

Medication Administration Records (MAR) charts showed when people had received their medicines and staff had signed the MAR to confirm this. Records were up to date with just one omission noted. We observed a member of staff giving out medicines at lunch time and this was done professionally and staff remained with the person to ensure the medicine had been taken before signing the MAR. Staff supported people to take their medicines which were ordered, received, administered and disposed of safely. Staff had completed medicines training which included competency checks. Storage arrangements for medicines

were secure and temperatures of storage areas were monitored to ensure medicines were stored at the correct temperature. Staff completed training in the safe administration of medicines and records showed that staff training was up to date.

The provider had taken steps to ensure the safety of people from unsafe premises and in response to any emergency situation. Contingency and emergency procedures and a member of the management team were available at any time for advice. The risks associated with moving people in the event of an emergency in the home had been assessed. Personal evacuation plans, a robust business continuity plan and home emergency evacuation plan were in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure. Regular fire safety checks and evacuations were completed by the maintenance person and staff and people who lived at the home had a very good awareness of the fire procedures in the home. One person told us, "We have fire alarms every week so we are all safe if it ever happened. It is very reassuring."

The service was clean and health and safety maintenance checks were in place, the system to report and deal with any maintenance or safety issue was effective. One person talked about the cleanliness of the home and said, "Spic and span." Other comments from visitors included, "(the cleaning) is very good, no issues," and "There are never any nasty smells, it smells fresh and clean."

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. There were 10 people who lived at Whitewaves Care Home at this time. There were three care staff on duty throughout the day, with a cook and a cleaner. One waking staff member was on duty at night with the registered manager on call and who lived in the grounds. People told us there were enough staff to respond to their needs. One person said "Always staff when I need someone, never had a problem." Relatives told us they had no concerns in respect of staffing levels but felt that a dedicated activity person would really benefit people at the home. We discussed this with the registered provider who said this was something they would introduce when residency increased. Staff did interact well with people and we saw some effective and caring one to one activities at times. Staff told us, "I feel staffing levels are sufficient," and "Good staffing arrangements, never feel we are unsafe, there are three of us plus the manager who will always help out."

Staff received training on safeguarding adults and understood clearly their individual responsibilities. Staff were able to describe different types of abuse and what action they would take if they suspected abuse had taken place. They were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse and the contact number for the local authority to report abuse or gain any advice. We saw that safeguarding referrals had been made appropriately to the local authority safeguarding team in a timely fashion. One staff member told us, "I wouldn't hesitate to flag up any concerns."

The organisational recruitment processes remained unchanged from the last inspection. All had Disclosure and Barring Service check (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. All had full employment history, references and evidence of checks on identity.

Requires Improvement

Is the service well-led?

Our findings

The feedback from people, staff and visitors about the leadership and culture in the home was varied. People told us, "Excellent here, I'm really happy here," and "The staff are supportive and kind." Comments from regular visitors included, "There has been a bit of an atmosphere, tense at times, but that has not affected the care," and "I have noticed changes when I have visited, I think that there are some tensions going on." Visiting health and social care professionals have stated there had been a serious communication breakdown with the provider who was also the registered manager. This was acknowledged by the registered provider. At the time of writing this report the issues had not been fully resolved.

Weekly and monthly checks were carried out to monitor the quality of service provision. These included health and safety, care plan monitoring, infection control audits, and audits of accidents or incidents and concerns or complaints. A representative of the provider also undertakes a 50 point assessment based on the Care Quality Commissions five Key Lines of Enquiry. This quality assurance assessment was carried out quarterly. The last one was undertaken 24 July 2017. The provider told us that their quality assurance systems had been effective at driving improvement. However we found that actions undertaken to improve were not always documented or recorded and therefore were difficult for the provider to monitor and take forward. The provider told us of improvements they had made to the management of medicines but this had not been reflected in the audit. Separate medicine audits were undertaken by the administrator but not linked in to the quarterly audit for complete provider overview. We also found that statements in the audit were not supported by any analysis. For example the last audit stated the weight charts were up to date, "There are monthly weight charts for each resident recorded in their care plans and included body max index (BMI)." During the inspection we found concerning discrepancies in some peoples' BMI, measurements and weight records over the past six months. There was no evidence that the recorded weight loss for certain people had been identified, analysed or of any actions taken.

Accidents and incidents whilst recorded had not been cross referenced and analysed to prevent a re-occurrence or identified to refer to a specialist health professional for advice.

The provider did not always have the required oversight and scrutiny to support the service. The provider had not taken action to monitor and challenge staff practice to make sure people received dignified care. For example, there were no documented observations of staff performance. Staff were kind in their approach but we saw that whilst assisting a person to walk with a walking frame they held on to the persons trousers to help them stand and to balance them as they walked. This was not considered respectful or good practice. Another person had a food protector placed around their neck at lunchtime without any conversation such as being asked if they would like one. The provider had not ensured that the care delivery and environment provided was consistently respectful and that care delivery was individual to the person. For example seek advice from an occupational therapist in how to support a person to remain independent using appropriate support tools. This meant that the quality assurance systems whilst in place were not fully embedded in to everyday practices. The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Before the inspection we received concerns from health professionals and local authority in respect of the behaviours of the registered manager who is also the registered provider. These concerns were being investigated by the Local Authority. At this time working relationships were difficult and if not resolved will impact on the running of the home and potentially impact on the health and well-being of people who lived at Whitewaves Care Home. The Local Authority were considering what action they were going to take if the situation was not resolved.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and staff knew where to access the information they needed. For example, staff were aware of the whistle blowing policy and how to blow the whistle on poor practice to agencies outside the organisation. They were also aware of internal processes for raising concerns confidentially.

Whitewaves Care Home had a registered manager in post and they were acting in accordance with CQC registration requirements. We have been sent notifications as required to inform us of any important events that took place in the home.

Staff said the registered manager lived on the premises and was always around to talk to. Records showed that staff meetings were now taking place and this enabled staff to influence the running of the service and make comments and suggestions about any changes.

Information leaflets were available in the entrance to the home about local help and advice groups, including advocacy services that people could use. These gave information about the services on offer and how to make contact. There was a copy of the most recent inspection report and the quality ratings given at the last inspection were displayed in the home. There was a suggestion box in the entrance hall of the home where people could raise issues or make suggestions.

Records were kept securely. All care records for people were held in individual files. Records in relation to medicines were stored in a locked room.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place and had not maintained accurate, complete and contemporaneous records in respect of each service user. Regulation 17 (1) (2) (a) (b) (c) HSCA RA Regulations 2014

The enforcement action we took:

warning notice for Regulation 17