

Care Homes UK Two Limited

The White House Nursing Home

Inspection report

Monkton Lane Jarrow Tyne and Wear **NE325NN**

Date of inspection visit: 15 December 2016

Date of publication: 08 February 2017

Ratings

Overall	rating	for	this	service
---------	--------	-----	------	---------

Good (



Is the service safe?

Requires Improvement

Summary of findings

Overall summary

At the last inspection on 19, 20 and 21 April 2016 we found a breach of regulation. Following the inspection the provider wrote to us to say what they would do to meet legal requirements in relation to medicines.

We undertook this unannounced focused inspection on 15 December 2016 to check that they had met legal requirements and to confirm that they had followed their action plan and made improvements to the service. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The White House on our website at www.cqc.org.uk.

The White House is a care home which provides nursing and personal care for up to 33 people, some of whom may be living with dementia. There were 27 people living there at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our focused inspection on 15 December 2016 we found medicines were managed safely. The provider had followed their plan and legal requirements had been met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the safety of the service in relation to medicines.

There were clear guidelines for staff to follow in relation to 'when required' medicines.

Medicines were stored appropriately and at the correct temperature.

Prescribed creams were recorded on medicine administration records.

While improvements had been made we could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement





The White House Nursing Home

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of The White House on 15 December 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 19, 20 and 21 April 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting legal requirements in relation to that question.

The inspection was undertaken by one adult social care inspector.

Before our inspection we reviewed information we held about the service and the provider such as the action plan the provider submitted setting out how they would become compliant with the breach identified at the previous inspection.

During our inspection we spoke with the registered manager, one nurse and one senior carer. We looked at medicine administration records for 10 people and other records related to people's medicine needs.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of The White House on 19, 20 and 21 April 2016 we found that the service did not have accurate records and procedures to support and evidence the safe administration of medicines. This was because appropriate codes for the non-administration of medicines were not always used, prescribed creams were not always recorded as administered, there was no specific guidance around 'when required' medicines and records relating to 'when required' medicines were not always accurate. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 15 December 2016 we found the provider had followed the action plan they had devised to meet shortfalls in relation to the requirements of Regulation 12 described above.

Prescribed creams were recorded as administered on medicine administration records. There was clear guidance and body maps in place for staff regarding the application of prescribed creams so this could take place in the right way and at the right frequency, in line with instructions on people's prescriptions.

Appropriate codes were used when medicines had not been administered, for example when a person did not wish to take them. Medicine administration records (MARs) we viewed had been completed accurately.

The arrangements for administering 'when required' medicines were safe. There were clear guidelines for staff to follow and each person who needed 'when required' medicines had an individualised support plan in place so staff knew when this was necessary. This meant staff had guidance on what signs to look out for, which was particularly important for people who could not always fully express if they were in pain or discomfort.

Medicines were stored in locked trollies secured to the wall, and records were kept of the temperature of the area. Records were also kept of the temperature of the clinical fridge. The temperature of the clinical fridge and the room where medicines were stored were within recommended limits for when medicines are considered most effective.

Unwanted medicines were returned to the pharmacy in a timely manner. Records showed medicines were returned on a monthly basis or more frequently if needed.