Meridian Healthcare Limited

White Rose House

Inspection report

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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 of White Rose House took place on 14 March 2016 and was unannounced. The service was previously inspected in July 2015 and found to be requiring improvement in all areas. There were breaches in the Health and Social Care Act 2008 Regulations in regards to person centred care, dignity and respect and nutrition. The service had completed an action plan detailing how they were to address these issues and on this inspection we found some improvement had been made but there were also further areas of concern.

White Rose House provides nursing and personal care for up to 64 older people. On the day of inspection there were 53 people living in the home, 16 of whom were in receipt of nursing care.

There was no registered manager available on the day we inspected. However, there was a relief manager in post who had been in the home for three weeks. 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.

People told us they felt safe and the staff we spoke with were able to explain what may lead them to report a safeguarding concern. Risk assessments were not always reflective of a person's needs which meant key aspects of minimising these risks to people in delivery of their care could be missed.

We found staffing levels were satisfactory in regards to meeting people's needs and staff responded promptly to call bells. However, we did highlight to the registered provider the issue with the call bell defaulting to an emergency alarm immediately which put staff under additional pressure to respond quickly as they were unable to determine the urgency of a call. They said they would take immediate action to rectify this.

Medicines were stored appropriately and people received their medication safely and in line with their prescriptions. This included any PRN (as needed) medication where the home had specific protocols in place to identify when this might be needed.

New staff had not received an induction prior to the start of the relief manager but this had been subsequently arranged. We found that ongoing supervision and training had not been given to ensure staff were suitably skilled and competent.

The home had a number of Deprivation of Liberty Safeguards (DoLS) authorisations in place. We found errors in a number of mental capacity assessments which conflicted with other information in people's care records which meant the service was not compliant with the requirements of the Mental Capacity Act 2005.

Recording was poor for nutritional intake and pressure care relief, especially on the residential unit as there

were no specific pressure care records for staff to follow. Pressure care was recorded in people's daily notes which meant it was harder for staff to determine what pressure care had been given and at what time.

We did see a much improved dining experience for people in both the communal areas and for those eating in their rooms from our previous inspection. Staff were caring in their approach with people, mindful of acknowledging them and respecting their privacy. It was evident that there had been consideration about how to support people with dignity.

The activities co-ordinator was a positive role model for the home and people spoke highly of their contribution. Care records were detailed but there was sometimes too much information which meant navigation around the file was difficult. This posed a significant risk as the service was using agency staff and they needed to be able to access key information quickly. Reviews were recorded separately to the care plan which again meant key information was not integrated and heightened the likelihood of this being missed.

People told us they liked living at the home and staff felt supported, especially by the relief manager. However, due to the inconsistent management over the past eight months there were lapses in quality assurance processes which had missed key areas for improvement.

We found breaches in Regulations 11, 17 and 18 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 the 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 always safe.

People told us they felt safe and staff were able to explain how they would deal with any concerns.

Risk assessments were not always focused on the specific risk to the person as some were generic.

Staffing levels were appropriate for the needs of the people in the home and medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not effective.

We found that staff had not received the necessary induction, ongoing support or training to ensure they were appropriately skilled.

Although the home had some DoLS authorisations in place, the mental capacity assessments were contradictory and did not always reflect people's presentation.

People's dining experience had improved greatly but there was a lack of accurate and contemporaneous record keeping for people nutritionally at risk and for those requiring pressure relief, especially in the residential unit.

Is the service caring?

Good

The service was caring.

Staff were observed to be caring, patient and kind, ensuring they spoke with people as they went about their tasks.

People's consent was sought in regards to any care tasks and staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The home had employed a motivated activities co-ordinator who was spoken of highly by everyone and had arranged a comprehensive programme.

Care records were difficult to negotiate due to the volume of information they contained meaning that care staff were at risk of missing key facts.

Complaints were handled informally as far as possible and in a thorough manner when more complex.

Is the service well-led?

Requires Improvement

The service was not always well led.

We observed that people and staff felt things were improving but the manager was in a temporary position. This lack of consistent management meant that audits had been missed which may have identified some of the concerns we found.

There was an open and transparent atmosphere in the home and we found that the registered provider was keen to improve, acknowledging the issues and seeking swift resolutions wherever possible.

White Rose House

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.

This inspection took place on 14 March 2016 and was unannounced. The inspection team consisted of four adult social care inspectors.

We had received information of concern prior to the inspection regarding staffing levels, length of time for call bells to be answered and conflicting information in care records. We had received notifications form the service regarding some incidents.

We spoke with eleven people using the service and three of their relatives. We spoke with nine staff including four carers, one senior carer, one nurse, the home administrator, the activities co-ordinator, the relief manager and the registered provider.

We looked at ten care records including risk assessments, six staff records, minutes of staff and resident meetings, complaints, safeguarding records, accident logs, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living in White Rose House. One person said "Definitely" and another told us "I feel alright and safe at night." A further person said "Yes, I feel safe. I don't do anything that I can't manage." A relative we spoke with said "I think my relation is safe but I am concerned about the number of agency staff." This was reiterated by a further relative we spoke with who also expressed concern about the numbers of staff on duty, especially at night.

On the day we inspected there were nine care staff and one nurse on duty. This included a member of care staff who was new and shadowing a colleague. The nurse and two of the carers on the residential unit were from an agency but the home had block-booked these members of staff to ensure as much continuity as possible for people living in the home. A staff member said "Staffing levels are getting better. A lot of staff left at the same time but there is recruitment at the moment. We are using agency staff in the interim." One person we spoke with said "My impression is that staff have lots to do. They're very busy but I do get the support I need".

The home had undergone an intensive recruitment drive and they were waiting for the required checks to come through so that staff could commence employment. The relief manager was keen to stress they "are not recruiting for the sake of it. They need to be the right staff." We looked at recruitment records and found that all applicants had completed an application form and details of their interviews were recorded. Appropriate references had been taken and the home had requested Disclosure and Barring Checks (DBS). The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at staffing rotas and had asked the home, due to a previous safeguarding issue, to audit their staffing rotas assessing both numbers and skills mix of staff. This had revealed that on five days and one night the home had been short staffed by one carer, however as the home was not fully occupied during this time this did not affect their staffing ratios which were achieved. The relief manager told us they were considering the balance of skills and experience more to minimise disruption as much as possible and to ensure the dependency tool which recorded people's support needs was updated regularly and used to inform staffing decisions.

One person did inform us they had to wait some time at night for the bell to be answered. They said "If they have to leave someone to get to you, then there aren't enough staff." We noted that the call bell was answered promptly by staff during the day. However, there was a concern that it moved to 'emergency' very quickly which meant staff were unable to determine the urgency of response required increasing workload pressures, and we brought this to the registered provider's attention who agreed an urgent maintenance call had been made. They advised us the call bell had been looked at a number of times over the past few months.

Staff we spoke with could identify the key signs of abuse. One staff member described what they understood by safeguarding and said that they would have no hesitation in reporting any concerns and would go

straight to the manager. They gave two contrasting examples of possible safeguarding concerns. One referred to the incorrect moving and handling of people and the other said "If a meal is just put in front of someone without asking them first what they wanted to eat". This showed the staff member had understood safeguarding in its widest context.

A different member of staff said "I would report any concerns and am aware of what to look for. This could include a person becoming quiet or withdrawn, or I may see some unexplained bruising." This same staff member was also confident in knowing how to report concerns about the practice of colleagues. They told us about an incident where this had been done and effective action taken as a result. Another staff member told us the importance of raising anything of concern as "It's their home" referring to the people living at White Rose House. Two staff we spoke with were aware of the whistle blowing policy and said they would not hesitate to call the local authority or the Care Quality Commission if there was no action from the manager.

We looked at safeguarding records and found the home had referred concerns on but not always on their own initiative. This was mostly due to the lack of management oversight as there had been changes in personnel. The local authority contracts monitoring team had conducted a series of visits and found areas of concern. These had been addressed by the home and we saw that investigations had occurred, identifying failings in care provision and putting in measures to address these lapses including further staff supervision and training. However, we were made aware at a recent meeting with the local authority about an incident which had not been reported to us and we asked the registered provider to complete an urgent notification and investigation into this concern. This meant that on this occasion the home had not followed the required notification process.

We inspected the accident and incident log and found that records had been completed in detail, giving an outline of the people and staff involved, any injuries incurred, immediate action taken to ensure a person's safety and what measures the home had taken subsequently to reduce the likelihood of a reoccurrence. Risks were measured in terms of whether harm had occurred and if so, the severity of this. Evidence of linking into people's care plans was recorded. We saw in one record "[Name] is known to the falls team who has given them a walking frame. Staff are to encourage [name] to use this where they can and encourage rest periods." There were completed body maps in people's care records to show where injuries had occurred. This showed the service was recording and responding to incidents appropriately.

We asked the relief manager what analysis took place of these incidents and we were given some graphs showing overall trends between August 2015 and the day of our inspection. There had been 95 slips, trips or falls out of a total of 107 incidents during this period averaging 17 per month. The majority were in people's own rooms with a slighter larger proportion between 2pm and 8pm followed closely by 2am to 8am. 63 incidents did not result in any harm to an individual. One person had had 20 incidents and the home had liaised with external agencies to consider a review of this person's placement as they were not able to meet their needs due to the level of cognitive difficulty. This shows the home had considered the impact of such incidents on people living in the home.

Risk assessments were in place with handwritten or typed care plans. Each person had been assessed against a dependency tool which looked at their level of need in regards to personal care, nutrition, mobility, behaviour and communication among others. We saw that there were both environmental and person specific risk assessments. The latter contained details of the identified risk and actions to be taken to reduce this risk.

We saw risk assessments in place for falls, choking, isolation, diet, specific health conditions and vision in

one care record. In the choking risk assessment it was recorded "[Name] has a dry throat and this can increase the risk of choking. [Name] is on a soft diet and staff are to check regularly at meal times to ensure they have access to cold water and when in their room, their call bell." In relation to diet in another record we saw "[Name] has a particular taste in food and if there is something they don't like, they will not eat any of their meal. Staff are to offer alternatives…. And seniors are to be made aware of any concerns." This shows the home had considered risks for each person and reflected their level of need.

Moving and handling plans recorded whether people had particular pressure areas, their falls history, any communication or behavioural factors and the level of assistance required. This all equated to an overall risk score determining whether someone was at low, medium or high risk. People's nutritional risks were also recorded and there was evidence that people were weighed monthly where required.

Formal reviews had been undertaken on a monthly basis and these provided details of the actions and changes to the plan. However, we noted the original risk assessment or care plan was not amended and the review information was recorded separately which meant it was difficult for a member of staff to identify the current plan of care and risk assessment easily. We brought this to the attention of the registered provider who agreed to review urgently. They explained the paperwork was about to change and shared copies with us of the new format.

We looked at how the home managed its medicines. We found that they were stored, administered and records kept appropriately. The nurse on duty at night took responsibility for booking in medicines, checking stock against each person's prescription and Medicine Administration Record (MAR) sheet. Each person's sheet had a photo and details of any significant condition such as diabetes or any allergies. We checked stock levels and they tallied with the records and saw that temperature checks were completed for both fridge and the treatment rooms.

We saw the home had PRN (as required) medicine guidelines in place detailing in which instances a person should be offered such medication. There were also records for the application of creams which were signed by the staff administering the cream and these were all checked by the nurse on duty. Staff responsible for medicine administration had all received the necessary training and had been subject to medicine competency checks. However, we noted some of these were due for renewal. They were aware of how to report any medication errors. The home also completed monthly medication audits which included observations of a medication round along with a local pharmacy who had visited in January 2016.

The home had completed their own internal infection control audit on 25 February 2016. This had identified issues around the lack of training for some staff in this area which was due for completion by the end of March. They were due a further visit from the external Infection Control Team.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with told us "Staff have skills and knowledge." This view was endorsed by the agency nurse who had worked at the home for some time said "The permanent staff are excellent."

We spoke with staff about their induction. One staff member told us they had been at White Rose house for three months but not yet had an induction. Although they were shadowing another member of staff this was a long time for a service to have someone in post and not be developing their skills. The relief manager had given them an induction booklet the week prior to our inspection once they had become aware of the situation and explained that they needed to access the online training package. When we raised this with the registered provider they seemed to be unaware of this issue. The staff member had their first day's training scheduled for the end of the week.

When we looked at staffing records we did not see any completed induction check lists or training. There was no evidence of probationary requirements which meant the home was not able to ensure all staff working met the required standard as they had not been assessed. This lack of induction was compounded as the staff member also told us they had not had any meetings with a manager since starting their position. However, they had felt supported by the staff team.

Two staff members who had worked at the home for some time told us they had received a three day induction which included all the key elements such as moving and handling and safeguarding but they had not received any regular supervision. We looked at supervision records and found that there was no evidence of any regular supervision since May 2015 and for some staff this had been as far back as October 2014. The lack of personalised support for staff had been noted at the last inspection. These examples evidence a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing as the service was not able to ensure suitably skilled and supported staff.

It was explained by the administrator at the home that a new system of e-learning had been introduced in September 2015 and staff were required to complete modules which comprised a section of knowledge which they worked through followed by an online assessment of their understanding. Following completion of this they received a printed certificate of completion and staff were then required to complete a further written assessment of their understanding. In the staff files we saw that people had completed the online element of the training and certificates were in place. However, only one staff member had completed the further written workbook element of the training.

We looked at the training records and found significant gaps. 100% of staff required an initial assessment of manual handling and 96% for safer people handling. A further 50% of staff had not completed basic life support training and 66% of both nurses and senior care staff required a medicines competency assessment as theirs had expired. The relief manager was fully aware of the gaps in training and lack of supervisions for staff and were in the process of trying to remedy this. They had arranged diabetes training for April and ensured staff accessed an induction as soon as possible. The relief manager also indicated they had access to in-house moving and handling training.

We saw improvements in numbers of staff who had received training in person-centred care and dignity following our previous inspection. One staff member who had attended the dementia training was keen to tell us "Before I had my training, I struggled but now I see it from the person's point of view. How would you feel if you woke up tomorrow and were told your parents had died, you were married and had children but your husband's died and you believe that you're coming back from school." This demonstrates the impact that effective training can have but the home had not ensured all staff had accessed this.

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. The application procedures for this in care homes and hospitals are 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 were being met.

Two staff we spoke with said that they understood Mental Capacity and DoLS but one staff member was unsure who actually had a DoLS in place. However, the other staff member was able to advise us "We always assume someone has capacity" and was aware of one person in their section of the home who had a DoLS. We looked at this person's care plan and found it was recorded they had capacity which was incorrect in view of the authorised DoLS in place. However, as a result this person's repeated attempts to leave the home to go shopping without the ability to assess the risk to themselves, the home had appropriately requested the DoLS. We asked a staff member how they would prevent this person from leaving the home and they advised us "I would try and talk [name] round if they try to leave as they can be persistent. However, they have not tried this in ages. I would document any concerns and report them." This shows that staff did understand how to support people safely.

We saw records that showed four people had a current DoLS authorisation in place with a fifth having had repeated applications being made but the last one had not yet been authorised. This demonstrated the home was aware of its responsibilities to ensure people were not unlawfully deprived of their liberty and that any decisions they took to restrict people's freedom was in their best interests.

Care records contained a two stage mental capacity assessment which indicated whether people had full capacity. However, not all this information corresponded. The relief manager was aware that some care plans needed further work in relation to mental capacity assessments as it was not always obvious that consent had been given by people with the necessary authority and further consideration was needed as to whether other people needed a DoLS application. There were some best interest decisions in people's files in regards to medication but this was not consistent across the home. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent as the home had not adhered to the principles of the Mental Capacity Act 2005 by ensuring consent, where required, was contained from the relevant person or in some cases, correctly applied the capacity assessment.

We asked people what they thought of the food. One person said "We get choices for what we'd like to eat. They're always on at me to drink. They make sure I drink plenty." Another said "The meals are very, very good. You usually have a choice; you can either have chicken or beef." A further person said "I enjoy the food." Most people we spoke with were positive about the food and told us if they didn't want what was on

the menu staff would always get them something else. One staff member told us "The dinners are brilliant; it's proper home cooked food." A member of staff also told us "A few people had omelette today as they didn't want what was on the menu." There was a notice on the ground floor indicating new sandwich options for people and asking for any further suggestions which showed the home had responded to previous concerns we had about not offering people choice.

We observed the lunchtime experience for both floors of the home and saw that the tables were laid and people were supported into the dining room. One person was reluctant to go into the dining room and staff respected this decision saying they would bring this person's lunch to their room which they did. The staff member later came to take away this person's empty plate and asked if they had had enough to eat and then brought the person a dessert. They said "There you are. Apple crumble. Is that alright for you?" This shows that staff were ensuring people were happy with their choices which was an improvement on our previous inspection.

The food looked appetising and people were offered a choice. The food arrived from the kitchen in a heated trolley and was served by kitchen staff in conjunction with the care staff who advised on what meals were needed for people. There was a greater level of interaction between staff and people in the room than we had observed on our previous inspection as staff talked while helping people with their lunch. One person with limited verbal communication skills was asked which drink they would prefer. The staff member checked with the person they had understood correctly before making it.

People who were unable to access the dining room were supported by staff in their rooms if needed to ensure they were able to enjoy their meal. Again, we observed some positive interaction. We spoke with one relative who advised us that staff were competent in the management of the percutaneous endoscopic gastrostomy (PEG) feed which enables someone with swallowing difficulties to receive nutrition directly into their stomach, and regularly flushed the PEG through as required.

We looked at how information was recorded for people deemed to be nutritionally at risk due to significant weight loss or other health factors. The relief manager advised us that each person now had a MUST (Malnutrition Universal Screening Test) score which indicated their level of need. There was regular monitoring of people's weights which were recorded in their care records. Where necessary, the home referred onto more appropriate support such as the GP or a dietician.

However, we saw conflicting information in some care records. In one record we noted a review of the nutrition assessment had taken place on 23 February 2016 which had identified two consecutive weight losses. As a result the GP had been called but the resulting action was noted as "no intervention, expected due to being frail. Permission to continue with monthly weights." We could not see any evidence of an updated specific nutritional care plan in place. Previously, the care plan stated that this person should be encouraged to have food and fluid and snacks in between meals. The care plan, which had been written on 6 September 2015, stated that this person "enjoys meals in the dining room and eats a normal diet." It was unclear from the records what the support for this person in relation to nutrition should be and we highlighted this to the relief manager who agreed to address this.

There was also an issue with the recording in food and fluid charts as amounts were not totalled and some had gaps in entries. It was also evident in the records we looked at that amounts were only recorded between the hours of 8am and 5pm. There did not appear to be any monitoring before or after these times. On one record for 11 March 2016 we saw the person had refused porridge but there was no further information as to what they may have eaten and this was the same for fluid intake. This lack of consistency in recording is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) 2014 good

governance as the home was not maintaining a contemporaneous record for each person where needed in relation to their nutritional intake.

We looked at pressure care records and found these also needed improvement. In one record it was noted the risk of pressure damage was high and staff needed to monitor this person's pressure areas regularly. However, we could not see that the care plan had been reviewed since 20 August 2015 which had identified the need for twice daily treatment on this person's heels. We could not find any records of pressure care being given to this person.

On speaking with a member of staff they were aware of the need for the specified pressure care but acknowledged that this was only recorded in the daily notes as opposed to specific pressure care records. As we did not see any completed daily notes by 3.30pm on the day we inspected we concluded that there was a lack of contemporaneous notes. We did see that the GP had been called to assess this person's weight loss but again, there were no clear records as to what food and fluids have been ingested on the day we inspected. This is a further breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) 2014 good governance as the home was not maintaining accurate records which could have meant incorrect pressure care was given.

One staff member we spoke with said they were aware of how to identify any pressure area concerns and the importance of using equipment properly. They advised us there were no pressure area care records logged in the residential unit. We did see in one care record in the nursing unit that a member of staff had spoken to a nurse on duty highlighting that a person had a pressure sore to their sacrum. Appropriate pressure relieving equipment was duly provided and effective monitoring has meant this area has now healed.

We asked people how quickly they had access to a GP or other health professional if needed. One person said "You can always see a doctor, you can go to a hairdresser here or have your nails done." One person had had an unwitnessed fall over the weekend prior to our inspection. When we spoke with them they said that they felt upset and were shaken up by the fall. We were told by staff that the person was visited by their GP that morning. There were specific care plans relating to falls and mobility in this person's records. Relatives also told us that communication was quick if such support was needed. We saw in care records that people were referred to external services such as the Speech and Language Therapy Service, chiropody and the falls team as needed and that visits were recorded.

Good

Is the service caring?

Our findings

We asked people if they thought staff were caring. One person said "I can't grumble at them, they're good. They're right good carers, I've no fault in how they're treating me, no fault at all."
Another person said "I like it. There's always someone to chat to." A further person told us "The staff are good and they look after me." One person told us how busy the staff were; "Sometimes they have the time but they've such a lot to do." One relative we spoke with said "Staff are very nice and very good."

We observed staff throughout the day talking with people in a respectful and caring way. One staff member greeted someone with "Morning [name]. You look nice this morning. It suits you, that colour." People were asked what they preferred and staff were seen to be giving people choices. Another staff member was seen speaking with a person who said "Oh, I'm hungry" and they replied "Well, let's get you something to eat then. What would you like?" The person's choice was subsequently brought to where they were sitting. As staff were asking people whether they wanted to go to the dining room for lunch, they did not rush them but spoke gently and enabled them to take their time to get up.

In preparation for the morning activity we saw one member of staff assist someone to the lounge. They asked the person where they would like to sit and after settling them, asked other people in the room if anyone would like a drink. A bit later we observed a staff member support someone who wished to move but needed support to do so. The staff member advised them "oh yes, I can help you with that" as the person was initially requesting the help of another staff member.

Staff members were complimentary about each other. One staff member said "They are really good - the team is one of the best, they're a knowledgeable team." A new staff member told us "I wanted to help out and it's nice. I enjoy sitting down and talking to people. Other staff have been very helpful."

People were smartly dressed and had accessories such as handbags and we noted that staff always acknowledged people when they walked past them.

One person said "They often say, are things being done right? We're sort of a family." Another person said "Staff are very patient and understanding. They always explain what they are doing." Consent forms had been signed for having photographs taken and for keys to people's rooms. One person said "I am asked my opinion before any care tasks are undertaken."

We observed care staff knocking on people's doors before entering a room and addressing people by their name. This happened at regular intervals during the day where staff checked on people not in the communal areas and spent time having a conversation with them. Staff appeared much more focused on the person than at our previous inspection rather than the task they were performing. This meant that the home had recognised the need for a culture change and this was evident on the day we inspected.

One staff member we spoke with said "People are given a choice of male or female carer, and people are able to make their own arrangements for support if preferred." This was also noted in their care records.

Another staff member said that people's specific cultural or religious beliefs were noted on their admission to the home. The staff member told us that the previous day a person had requested a priest and the home had arranged for one to visit.
Staff were also aware of the importance of preserving person's dignity. One staff member told us "I always ensure doors are closed and I never provide care to women who do not want a male carer. I try and ensure people feel comfortable and not embarrassed."

The relief manager was unaware if anyone in the home had an advocate but we did see records of advocate involvement in relation to more complex decisions. Some people also had advanced care plans and Do Not Resuscitate forms in place along with an emergency care plan in case they needed to attend hospital.

Requires Improvement

Is the service responsive?

Our findings

People told us they enjoyed the activities the home arranged. One person said "We quite enjoy it especially when the activities co-ordinator comes in. They help us do all sorts of things. Skittles and bowls- sometimes we pass to each other." Another person told us "If we want to go out we can go shopping, sometimes someone will take us."

We spoke with the activities co-ordinator who had a person-centred activity plan and said "I try to get the activities as inclusive as I can. I still offer to people in their own rooms. However, there's only some things you can do without being patronising." They tried to ensure that each person was seen at least once a day for a chat. They had worked on finding out about each person's life history and what they enjoyed doing. Although activities were recorded on an activity sheet, there was no specific care plan which related to social and emotional wellbeing. These activity sheets had been generated as result of the home's previous inspection to evidence how people's social and emotional needs were being met. Each staff member was responsible for their completion thus ensuring people's emotional needs were "everyone's responsibility" rather than just the activities co-ordinator.

We saw there were group activities planned on a daily basis which included dominoes, volley ball and craft activities linked to celebrations such as Easter Bonnets and a planned Easter baking and Easter egg making session. Four people who had been interested in gardening had planted some tomato seeds and one person who was on the nursing unit had been provided with seeds so that they could also be involved even though they were unable to attend the planting session downstairs.

During the afternoon we observed some people playing with a large inflatable ball in the downstairs lounge and several people were really enjoying this. We saw that one person did not want to join in and this was respected. The activities co-ordinator explained that they tried to find something that each person enjoyed and if a person was reluctant to join in with group activities and preferred to remain in their room they would talk with them to see whether there was anything they would like to do. There was a 'trolley shop' which we were told went round each week to each person with sweets and toiletries for sale.

The activities co-ordinator explained that they had a range of different singers and entertainers which people enjoyed. These included a range of local choirs and singers including children from a local school who came to sing at Christmas. In addition a local vicar comes ran a service once a month at the home and we were told one person living at the home ran a reading group with poetry readings which some people enjoyed. In the summer an organisation came with birds of prey and owls for two different sessions which the activities co-ordinator said "People loved it."

Work was ongoing in establishing links with the Women's Institute (WI) as many people living in the home used to belong to the WI. The activities co-ordinator said "Why should that stop if they've paid for their membership?" We asked them what they felt their biggest achievement was and they said "This week has been [name] letting me do a hand massage." We saw evidence that activities were discussed at both resident and staff meetings on a regular basis showing how the home was keen to integrate this element of

its service.

We asked people if they had the choice as to when to get up. One person said "I get up when I like. Staff come when I ring my alarm." Another person said "I'm so used to getting up early; I'm up by 6.30-7.00 and have breakfast at 8.00." Permanent staff had a good knowledge of people's routines and preferences. One staff member told us "[Name] rings their buzzer a lot. They mostly need reassurance which I give. Another person has limited verbal skills and they bang their cup on the table to indicate they want another drink."

We looked at care records and saw they contained a photograph of the person. This was not always dated. There was also a 'this is me' sheet which gave key information about a person. Care records contained care plans for each area of need a person had such as communication, eating and drinking, personal care and mobilising. Each of these areas had agreed aims and outcomes with specific support needs detailed.

People's preferences were noted such as whether they preferred a bath or a shower, and also information about hair care, nail care, oral care, vision, hearing and diet amongst others. In one record it was noted that a person's preferred bedtime routine including the time, number of pillows and having their small bed light on. However, in other records some of the language was not person-centred. For example in one care plan for oral care it was recorded "Staff to check client's mouth." The relief manager advised us that care records were being amended in line with a new system.

Care records were personalised and reviewed on a monthly basis. One person said "We have a meeting every so often and any member of your family can come." However, the reviews and any changes as a result of these were not incorporated into the care plan which made finding the latest information very difficult and could pose a risk for staff of delivering inappropriate or unsafe care, especially those who were from an agency who may miss key information. One staff member said "I do not have time to sit down and read through people's plans." We did not see evidence of any impacts associated with these risks. This is a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as care records did not always reflect a person's current needs as the information was not recorded in the most accessible format and care plans were not amended to reflect any changes.

In one care record original assessments from 2009 were at the front of the file but this person's needs had changed significantly as they now needed nursing care. The latest review, which was in the file further on, was held on 23 February 2016 showing how this person's needs had changed but as they were not incorporated in the care plan these changes were not initially evident. The relief manager was aware of the changes that were needed and acknowledged the risks associated with such confusing records. Daily notes appeared to be completed at the end of the shift and in the residential unit.

Information was limited in regards to personal history and preferences. We asked one person if staff had discussed with them how they preferred things to be done and how they liked to be looked after. They told us meetings were held in the office and people could invite their relatives if they wished to do so. We did not see any records which indicated that relatives had been involved in any review meetings. However, staff advised us they had a programme of 'resident of the day' where a specific person's care records were looked at in detail and also that people were invited to monthly care reviews.

There was a 'service user preferred outcome' sheet in place which described some of the things that people liked to do including hobbies such as painting and drawing. The section on "Do you need support to pursue this outcome?" had not been completed. We asked one person if they had been supported to pursue their hobbies and they said "occasionally".

The home had two handovers per day, one for the morning shift and the other for the evening. Notes were kept but they were brief and we found significant gaps in recording. Comments were task-focused and often limited to one word answers such as 'bathed' or 'showered'. This meant that staff coming on shift may not always have had the detailed information required to support a person most effectively.

We asked people living in the home if they knew how to raise any concerns. One person said "If there's the smallest thing, I'd pop into the office. They sort it out if you've lost anything." Another told us "I would find someone in authority and explain my problem." A staff member advised us "If the issue was small I would address it but if it was more significant, I would signpost the person to the manager."

We spoke with the relief manager about complaints but they were not aware of any recent ones. However, one relative we spoke with advised us their relation had recently complained about some staff members and they were awaiting the outcome of this. People had access to complaints and compliments leaflets so they could describe their experience of care. We observed a relative speaking to a member of staff about concerns regarding laundry. This was duly noted and the member of staff sought a member of the domestic staff to liaise further. This showed the home was keen to seek early solutions to any potential difficulties.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager available on the day we inspected. However, there was a relief manager in post who had been in the home for three weeks. 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.

We asked people how they felt living at White Rose House. One person said "It does feel like home. It can be recommended." Another told us "People seem to get on well together. They come round and ask would you like this or that? Some of the relations bring their dogs, they're all well behaved." A further person said "Nothing could be improved upon."

One relative we spoke with said "The home had been through a bad time as they had lost their nurse who had been very good. There have been lots of issues but they are pulling their socks up now." They told us they felt the main problem was in not having consistent staffing but were aware the home was trying to resolve this issue. We asked them if their relation had a keyworker but they advised us not and this meant that there was no oversight into this person's care and communication was not effective between staff. They told us of a recent incident where specific instructions had been left for staff but they had ignored them. They felt this was due to the constantly changing staff on duty. However, another relative said "We're happy with the care here. We chose this home; others are not a patch on this."

People living in the home took an active role where they were able in the relatives and residents' meetings which were held regularly. Two recent meetings had included discussions around staffing and the problems in having so many agency staff. We reviewed the notes taken from these meetings. An incident was described regarding a shift where an agency nurse had failed to turn up had been discussed and this had been followed up by the local authority and the situation explained by the registered provider. Other issues discussed included the "employee of the month" had been replaced by a "kindness in care" box for nominated acts of kindness observed. We saw this promoted on the main display board. We saw that communication was raised as an issue and it was suggested that significant dates and events could be announced at lunch time when the majority of people were sitting in the dining room.

Staff spoke highly of their colleagues. One told us if they approached their colleague "I know that I'll go to them and they'll give me the answer." Another staff member told us the best thing about being at White Rose House was "The staff; how nice they've been to me especially the activity person. They get everyone involved." A newer member of staff also emphasised how supported they felt. They said "Someone always offers to help. The team help a lot." A different member of staff who was also relatively new said they had discussed their training needs with the relief manager and this had been dealt with promptly. They felt the home "had individualised needs at the centre of care."

There was also positive feedback about the relief manager who we were told by more than one staff member was approachable and was happy to be asked anything. One staff member said "They are so nice. I

feel as though I can go to them with anything." Another told us "Management have started to listen. The relief manager is fantastic." This was especially important in view of the management changes the home had seen since our last inspection. People living in the home were also approached by the relief manager who had agreed to attend their weekly discussion group to share any relevant information with people. The relief manager had also arranged fortnightly evening 'surgeries' where people or relatives could come and discuss any concerns.

At the previous inspection in July 2015 we found breaches in regards to person-centred care, dignity and respect and nutrition. We found, during this inspection, these areas had been rectified. However, we found further breaches in regards to seeking people's consent for care, staffing and good governance. The registered provider was unable to demonstrate they had quality oversight of the care being received by people living at White Rose House due to the lack of care plan audits which would have identified the concerns we noted, the contradictions and errors in application of the Mental Capacity Act requirements and lack of staff supervision. This meant that the service was not always able to assess, monitor and improve the quality and safety of the service provision. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relief manager was under no illusion as to what work still needed to be done and they had only been in post for three weeks at the time of our inspection. They were very conscious of the need to boost staff morale following the recent periods of upheaval and so were developing action plans to tackle areas of under- performance. They were keen to develop more transparency about events but felt staff were dedicated and committed to their role. The relief manager told us they were receiving the support they needed to facilitate change from the registered provider.

The relief manager explained they had arranged training for all the new staff which we saw evidence to ensure staff had the knowledge and skills to follow correct procedure rather than relying on colleagues for guidance due to the risk of incorrect guidance being offered. They were also mindful of the need to balance the amount of changes so that staff did not feel overwhelmed. They were very aware of the issues with the care records and were keen to implement the new system as this would evidence more clearly what the person living in the home thought about their care needs, any appointed representatives and the staff at the home. They were working on a target of one record per week per unit to ensure that quality could be checked. In the interim the original care plan would remain in place so that key information was not lost.

Staff told us about a meeting held the previous week which had informed them of the changes in relation to the management cover at White Rose House. The event had been an opportunity for staff to discuss any concerns directly with the registered provider. This had been the second event in as many months. The relief manager was keen to say they felt that staff were "working well as a team and working better. Things were frantic when I first arrived but I've stressed to staff don't rush, get it right." We saw that the home had arranged monthly staff meetings ensuring all had access to information and the opportunity to discuss any concerns and share good ideas which one member of staff felt confident to do.

In addition to these monthly meetings there was a daily 'flash' meeting where key personnel in the home met to discuss any issues pertinent to that day. This also included discussion around the 'resident of the day' where focus on ensuring their records were accurate was considered. Notes were made of the meeting which was important as it included a discussion around the timing of lunch and the feedback people in the home had given.

We asked to see the home's quality assurance programme and found evidence of some audits. A 'catering safely' audit had been completed in February 2016 which had identified a couple of action points. We noted

these had been completed in March 2016. There was also a comprehensive mealtime experience audit which had been completed on a very regular basis. This had considered areas such as the presentation of the dining room, how people were treated on entry to the room, choices offered to people and checks made to ensure everything was satisfactory and the general feedback from the meal. Again, some minor issues had been noted on an audit from 2 March 2016 but we did not find any major issues on the day we inspected. It was evident from the observations we conducted at lunchtime that these practices were embedded in the day to day care people were receiving.

The relief manager informed us they had already completed a spot check visit at night although we did not see any written evidence of this. They explained the three homes linked to the registered provider in the area shared manager cover so 'out of hours' staff always had access to a manager for any emergency.

We saw that all necessary equipment checks had been carried out as required. We did discuss with the registered provider the problems with the call bell system which they assured us they had followed up again. We also brought to the attention of the relief manager a fire safety audit which had been completed in October 2015 and for which we could not see any further action having been taken despite there being a number of actions identified.

We saw a new residents and relatives' survey form which was due to be sent out imminently. There had not been one sent out since our last inspection. There was an easy read format alongside a more in-depth survey to ensure as may views as possible were collected. The registered provider had set out a clear process to ensure a report would be compiled, answers collated and an action plan drawn up to evidence that they had listened to the feedback.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The home had not consistently applied the correct mental capacity assessment or obtained consent from the relevant person where a person lacked capacity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The home was not keeping contemporaneous care notes for people nutritionally at risk or in receipt of pressure care and there was a lack of quality oversight due to minimal use of audit tools.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The home had not ensured all staff received an induction, ongoing support or the necessary training to be a skilled workforce