CareQuality Commission

CC Whitelodge Limited

White Lodge Care Home

Inspection report

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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

About the service
White lodge Care Home is a residential care home providing personal care and accommodation to up to 25 people, including people living with dementia. At the time of the inspection they were supporting 20 people. Accommodation is arranged over two floors in single bedrooms. There are two communal lounges, a dining room and access to a garden and patio area.

People's experience of using this service and what we found
Risks to people using the service had not always been assessed. Plans were not always in place to mitigate these risks. There was a lack of guidance and information for staff about some risks which meant people were at risk of receiving inappropriate or unsafe care and treatment.

We received mixed feedback about the staffing levels in the home. The provider did not have a robust or effective system in place to determine the number of staff required to meet people's needs. Suitably trained and competent staff were not always available on-site to administer people's medication. Not all the required checks had been completed as required to help ensure people were protected from the employment of unsuitable staff.

External medicines were not always administered as prescribed, the operations manager told us they would investigate this. The effectiveness of a person's medication with a variable dose was not monitored to mitigate risks to the person from their condition. We have made a recommendation about the management of these medicines.

The system in place to identify, asses and mitigate risks to people from the quality and safety of the service was not always effective. We received mixed feedback from staff about the culture in the service. Staff views had not been formally sought and analysed over the past year.

People's relatives told us their relatives were safely cared for in the home and they had regular communication about their relative from staff. Restrictions on visiting meant relatives had not been able to have in person contact regularly inside the home over the past year. People we spoke with who were able to tell us about their care told us they felt safe and well-cared for in the home.

Rating at last inspection
The last rating for this service was Good (published 03 March 2020).

Why we inspected
We received concerns in relation to the management of medicines, staffing levels, people's needs in relations to falls and moving and handling, leadership and culture. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for White Lodge Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to safe care and treatment, staffing fit and proper person employed and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

White Lodge Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been recently appointed who would be applying for registration, we have therefore referred to them as 'the manager' throughout the report.

Notice of inspection
We gave the service 30 minutes notice of the inspection visit as we needed to be sure the inspection could be undertaken safely.

What we did before the inspection

We reviewed information we had received about the service since the last inspection including notifications. Notifications are information about specific important events the service is legally required to send to us. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We received feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff, including the manager, housekeeper, activity staff member and a care assistant. We spoke to two service users and we spent time observing the support and interactions between people and staff. We also reviewed the environment and a range of records. This included three staff recruitment records, four care plans and multiple medication records.

After the inspection
We spoke with a further five care staff members by phone. We spoke with three people by phone and seven relatives. We continued to review care records in total for five people. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● At the last inspection people's risk assessments had not always been updated following an incident.
● At this inspection we found not all risks had been fully assessed or plans put in place to mitigate them. For example, we found one person had experienced a seizure and was prescribed medication for epilepsy. However, no risk assessment or care plan was in place which would inform staff of the actions they should take to monitor the person's condition, recognise and respond to a seizure or what to do in an emergency as a result of a seizure. Although staff had recently completed an eLearning course in epilepsy awareness three out of four staff, we asked told us they did not feel confident in responding to a seizure or their knowledge was limited. This was significant because full information or guidance was not available to staff in the care plan or risk assessment should they need to rely on it.
● In addition to a seizure this person had also experienced two unwitnessed falls. Although a falls risk assessment was in place this provided limited mitigation measures and we saw no regular recorded checks throughout the day were required of staff to monitor this person. This is important to check the person has not been injured by a fall or a seizure.
● Risks to people from choking were not always safely managed. One person had experienced a choking incident in February 2021. Following this a referral had been made to the Speech and Language Therapy team (SaLT). The SaLT team had replied with a recommendation to alter the consistency of the person's diet and provided information about accessing other related guidance. However, there was no evidence this guidance had been considered, shared with staff or the person and whether the risks to the person from eating higher risk foods had been assessed with them. The person then experienced a further choking incident on 2 March 2021. This incident occurred while the person was eating a high-risk food. Although staff were with the person as part of their planned care, not all staff we spoke with felt confident to respond to an episode of choking.
● A second person's choking risk screen indicated risks to them from choking. Their care plan stated they required a modified diet and thickened drinks. Information about the fluid thickener level was not clear in their care records. The thickener level was stage one in their choking screen and stage two in their care plan and stage one in their SaLT assessment. There was no risk assessment in place to guide staff about this person's choking risk. In addition, this person's food and fluid intake were being monitored due to weight loss. No risk assessment was in place to guide staff about the nutritional risks.
● For a third person who had experienced unplanned weight loss and for whom staff told us they cut up their food due to risk of choking there was no risk assessment in place for either choking or nutritional risks. Not all staff were aware of this person's needs and areas of risk.
● A person's daily records described an incident where a person had been injured whilst distressed. This incident had not been reported or reviewed and no risk assessment had been implemented to mitigate risks

to the person and others from this behaviour.
● We found risks associated with people's skin and mobility had not always been assessed. For one person who had experienced recent falls, their care plan and risk assessment had not been reviewed following the falls. For another person who was at risk from constipation a risk assessment and consistent monitoring of their bowel movements was not in place. This was important because the person was unable to clearly verbally express their needs and this condition caused them pain and distress at times.

The failure to assess risks to the health and safety of service users and to do all that is reasonably practicable to mitigate those risks placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checks including fire safety, gas and electrical equipment were undertaken and a business continuity plan was in place in case of emergencies.

Staffing and recruitment
● At the last inspection we received mixed feedback about staffing levels in the home. At this inspection we continued to receive mixed feedback about staffing levels. Following the last inspection, the operations manager told us they would implement a tool to calculate staffing levels based on people's dependency needs. In the PIR returned on 6 February 2020 the provider stated they used this tool. However; at the time of the inspection the tool was not in use and was a planned development.
● The service supported people with a range of dependency needs including people who required two care staff for personal care, people at high risk of falls and seizures and people with behaviours that may challenge others. At times only two care staff were available for all 20 people this meant if two staff were supporting one-person, other people could be left unattended and at risk due to their needs. A staff member said, "We would go to them (people who required two staff) and everyone else left unattended."
● The manager and operations manager told us they used observation and staff feedback to assess the staffing level required. However, there was no record of these processes.
● A call bell system was in use, The operations manager told us this system did not have the facility to produce a report to show waiting times for call bells which would enable response times to be monitored. We did not hear call bells ringing for long periods. People we spoke with who could use the call bell said staff came "Quite quickly" and one person added "They are all overstretched. They could do with more staff".
● Of the eight staff we spoke with, one staff member said there was "No problem" and another said night staff levels were OK although it was difficult to meet all people's needs when getting ready for bed. Other staff said there were not always enough staff to always meet people's needs. One staff member was concerned people could experience neglect and be at risk of harm.
● During our site visit we observed staff were not allocated to the lounge in the morning although at least two people at risk of falls were in the lounge. A staff member told us staff were not usually allocated to the lounge.
● There were not always suitably skilled and competent staff on duty to meet peoples needs at all times. Not all-night staff were trained and checked as competent in administering medicines. This meant people who may need medicines on an 'as required' basis for example, for pain relief would have to wait for the staff member on-call to travel to the service. The manager told us this had not occurred, however there was a risk people's need for 'as required' medicines could not be met in a timely way. Training and competency checks were underway at the time of the inspection.
● Staff told us, and the training matrix confirmed, they had been required to do a large amount of e- learning training, over 30 courses in February 2021. A staff member told us the training had not been effective because it "Was really rushed" and they were required to complete this over two weeks. Another staff member told us they had not found this useful and staff could skip through to the end test to compete the

training without studying all the content.
● Some staff did not feel they had been given practical guidance and information to meet the needs of people they supported and would not be confident to respond to a choking incident or a seizure. We spoke to the manager and operations manager about this and the operations manager told us they would investigate this. At the time of the inspection staff were in the process of completing eLearning training in dysphagia and choking and epilepsy awareness. The provider was planning to introduce competency assessments to check staff skills following the eLearning.

The failure to ensure enough suitably qualified, competent, skilled and experienced staff at all times was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the previous inspection not all the required checks were in place to show people had been recruited safely. The operations manager addressed this at the time of the last inspection. At this inspection not all the information about staff recruitment was available on-site. We were sent information following the inspection. We found two of the three staff recruitment files we reviewed did not contain a full employment history or an explanation of gaps in employment.

The failure to ensure all the required information specified in Schedule 3 was available for each person employed was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People were prescribed external medicines such as creams, ointments and lotions applied to the skin. The administration of these were either recorded on the person's Medical Administration Record (MAR) or on a 'creams chart'. We noted there were frequent entries in the creams charts of these preparations being 'Not required'. Including those which were prescribed to be applied daily. The manager and operations manager said this was because people did not always want or need them applied even though they were prescribed to prevent people experiencing skin problems as described in their care plans. For example, two people had prescribed creams to be applied twice daily these had only been applied twice in the previous 12 days. There was no record this had been discussed with the prescriber or that people's skin had been regularly checked by staff.
● For another person we noted they were prescribed two external medicines and there was no evidence these had been used as prescribed in the past month in line with the person's care plan.
● The operations manager told us they would investigate the administration of external medicines.
● One person was prescribed regular medication for constipation. The dosage could vary depending on the person's symptoms. There was no guidance for staff on when to adjust the dose and monitoring of the person's bowel movements was not consistent to show the effectiveness of the medicine.
● We noted PRN protocols did not always contain information required to support staff to administer them in a person-centred way. The manager told us that improvements were being made to PRN protocols. These provide guidance to staff on the administration of medicines given 'as required' for symptoms such as pain relief, agitation or bowel issues.

The failure to ensure the safe and proper management of medicines was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely, and storage temperature was monitored.
● We observed a staff member administering medicines which they did in a calm and appropriate manner.

People and relatives told us they were satisfied with the way medicines were managed in the home and a person said, "They bring me my medication and a good drink to wash it down."

Preventing and controlling infection
● We were somewhat assured that the provider was meeting shielding and social distancing rules. The manager told us they had been unable to get people to maintain social distance in communal areas as people would move to sit closer to each other.
● We were somewhat assured that the provider was using PPE effectively and safely. Risks associated with touching people other than when providing personal care had not been assessed and PPE guidance was not always followed when this occurred.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules in place but unable to be fully completed due to staff resources. This was being improved with further recruitment to cleaning posts.
● We were assured that the provider was preventing visitors from catching and spreading infections.
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● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
We have also signposted the provider to resources to develop their approach.
● We discussed with the operations and service manager how positive it was they had not had to experience an outbreak of COVID-19 in the home to date.

Learning lessons when things go wrong
● Accident and incidents were audited monthly to check action taken. The accident and incident log did evidence that action was taken following accidents and incidents such as monitoring and referral to health care professionals. However, it was not evident there was a system for learning when incidents occurred to help prevent a reoccurrence. We saw the team meeting minutes dated 4 February 2021 recorded a staff discussion on incidents was planned to start from March 2021.
●We found one example of an incident recorded in a person's daily notes which resulted in an injury that was not reported by staff. The managers were unaware of this incident and told us they would follow this up with staff. This meant not all staff were clear about their responsibilities to report incidents and people's safety could be compromised.
●Whilst a monthly falls log and three-monthly falls analysis was in place. Neither document identified any trend information such as; times and locations of falls to identify factors to help prevent a reoccurrence.

Systems and processes to safeguard people from the risk of abuse
● All of the relatives we spoke with told us they felt the person using service was safe and well cared for. Relatives had not been able to visit regularly during the COVID-19 pandemic which made it difficult for them to comment on some aspects of the daily working of the home. One person told us they did not feel safe, but the manager and operations manager were aware of their concerns and these has been acted on. Other people told us they felt safe.
● The provider had a policy and procedures in place to guide staff on the action they should take if they had concerns of abuse. Staff were able to tell us about the signs of abuse and how and to whom they would report these.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● We found systems in place to identify and act on quality and safety concerns were not always effective. For example; a care plan audit was completed in February 2021 and had not identified any of the concerns we found, as described in the safe domain of this report. This included a lack of risk assessment and guidance to mitigate risks to people and guide staff how to support people safely. This meant people were at risk of receiving inappropriate and unsafe care.

● Although food and fluid monitoring records had been put in place for people with nutritional risks these records were not fully completed for all the people we looked at and would therefore be ineffective.

● At the last inspection we identified improvements were required in the system used to determine the staffing levels in the home. We also identified improvements were required to ensure safe recruitment practices. We were given assurances that these improvements would be made. At this inspection we have found improvements in these areas have not been made or sustained.

●Other audits were completed but required improvement to be effective. For example; the medication audit dated 26th January 2021 identified several actions for improvement however a target date for completion of these actions had not been set and we found concerns regarding the management of some medicines. There was a lack of trend analysis for falls to show where and when falls occurred which helps identify actions to prevent a reoccurrence and mitigate risk. An infection Control audit dated 4 February 2021 identified action was required in several areas, such as staff wearing jewellery and the need for a carpet cleaning schedule but did not identify by whom and by when.

The provider had failed to operate an effective system to assess monitor improve and mitigate risks to the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At the time of this inspection a registered manager was not in post. A manager had been appointed and we were told they would be applying for registration. Since the previous inspection in January 2020 there had been two managers of the service. There had been consistent oversight of the service by the operations manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed feedback from staff about the culture in the home. Some staff told us they did not feel listened to, appreciated or always treated equally by managers. When asked about the vision and values of the service a staff member said, "They are not talked about." Another staff member said, "Well I think that all the intention is there, owner and managers hope staff carry out what is supposed to be." Other staff said the manager was approachable and "Everyone gets along."
● Team meetings were held regularly, and the minutes showed information was shared with staff. Whilst minutes showed that 'any other business" was raised there was little evidence of staff voices or feedback. A feedback exercise had not been carried out with staff over the past year to evaluate staff experience in the service. The manager and operations manager told us that staff were asked for feedback verbally during supervision. Records showed staff had received a supervision in February 2021.

We recommend the provider consider current guidance on staff engagement and take action to update their practice accordingly.

● The provider had made the decision not to allow visitors into the home during this current national lockdown because they did not feel they could accommodate visitors safely. The provider had enabled other means of contact using the phone and social media. No one received visits apart from people at the end of their life and two people had window visits. Although the provider had processes in place to risk assess visits for people, we did not find they had adhered to these or done everything possible to enable all people to have visitors in line with government guidance. The operations manager told us they would be facilitating visits from the 8 March 2021.

We recommend the provider always implements current guidance on visiting.

● People and their relatives spoke positively about the leadership in the home. Some relatives commented on the changes in management over the past year but felt this had not had an impact on the care people received. Their comments included, "I have met the current manager (name) a couple of times and she seems very nice and approachable. The home appears to be well managed and efficient. All the staff seem happy and I've got to know a few (name) is very bubbly as is (manager). I am happy he is being well looked after". And "The new manager is (name) the old one was (name) although I am not sure if she has taken over completely. There have been quite a few changes of staff over the year which they haven't communicated but there doesn't seem to have been an impact on care".
● The manager and operations manager told us that staff had been thanked for their work during the pandemic by the provider and managers. Staff had been given gifts and bonuses in appreciation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team were aware of their responsibilities under the duty of candour, which requires providers to be open and transparent if people come to harm. Accident and incident records showed information about these occurrences were shared with the relevant people.
● Notifications about incidents had been submitted to CQC as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●People had been consulted on their views and experience of the service using a questionnaire and these were complete between December 2020 and February 2021. We saw feedback from people had been collated and analysed. Actions for improvement were identified and people's concerns had been addressed with them. People had fed back they missed visiting entertainers and of the eight respondents four did not

feel there was enough access to activities and entertainment during lockdown. The provider's development plan showed they were planning to introduce weekly meetings to plan activities in conjunction with people.
●People's relatives were asked for their feedback on the visiting restrictions and other aspects of the home during the lockdown in June 2020. Nine relatives had replied with satisfied answers or unable to comment, and thanks to the team.

Working in partnership with others
●The provider was using Tele Med which enables people to be seen by a healthcare professional on the computer. This meant access to assessment following an accident or injury was promptly available.
● The GP had regular weekly calls with the service and the operations manager said they were "Accessible and supportive of people's needs."
● Records showed referrals were made to other healthcare professionals when required.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to assess risks to the health and safety of service users and to do all that is reasonably practicable to mitigate those risks which placed people at risk of harm. The provider had failed to ensure the safe and proper management of medicines. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to operate an effective system to assess monitor improve and mitigate risks to the health, safety and welfare of people using the service. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed failure to ensure all the required information specified in Schedule 3 was available for each person employed.

	Regulation 19 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure enough suitably qualified, competent, skilled and experienced staff at all times. Regulation 18(1)