HC-One Limited

White Gables

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected White Gables on 6 October. The inspection was unannounced. The last inspection took place on 10 January 2014 during which we found that the provider had met all of the outcomes we inspected.

White Gables provides care and support for up to 55 older people, some of whom experience needs related to memory loss requiring high levels of care and nursing.

The building is split into three different units with each focusing on either nursing or personal care. It is located on the edge of a village on the outskirts of Lincoln and is surrounded by fields and woodland.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are

Summary of findings

'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.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of the inspection 21 people who lived within the home had their freedom restricted and the provider had acted in accordance with the Mental Capacity Act, 2005 DoLS.

People were safe living within the home. Staff knew how to recognise and escalate any concerns so that people were kept safe from harm.

Staff had been supported to assist people in a personalised way. They provided care as set out in each person's care record and we found this helped to reduce the risk inappropriate care being given. There were clear arrangements in place for ordering, storing, administering and disposing of medicines.

People were provided with a choice of nutritious meals. When necessary, people were given extra help to make sure that they had enough to eat and drink. People also had access to a range of healthcare professionals, including GP services and specialist healthcare services.

People were treated with kindness and respect. They were able to see their friends and families when they wanted. There were no restrictions on when friends and families could visit the service and visitors were made welcome by the staff in the home.

People and their relatives had been consulted about the care they wanted to be provided. Staff supported the choices people made about their care and people were offered the opportunity to pursue and maintain their interests and hobbies.

There were systems in place for handling and resolving complaints. People we spoke with and their relatives were aware of how to raise any concerns they may have.

The provider and registered manager had systems in place to enable them to continually assess and monitor the quality of the services they provided. They had taken steps to address issues identified such as vacancies within the staff team and odours within the home.

Summary of findings

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 safe.

People felt safe living within the service. Staff knew how to recognise signs of potential abuse and how to report their concerns.

Vacancies in the staff team were managed to ensure people received the care and support they needed and wanted.

Good

Is the service effective?
The service was effective.

People were helped to eat and drink enough to stay well and received all the healthcare attention they needed.

People were supported to make their own decisions and appropriate systems were in place to support those people who lacked capacity to make decisions for themselves.

Staff had received training and were supported to provide the care people needed.

Good

Is the service caring?
The service was caring.

People were treated with kindness and respect and staff took account of their wishes and preferences.

People's privacy and dignity were maintained.

Good

Is the service responsive?
The service was responsive.

People had been consulted about their needs and wishes and they were able to enjoy activities and interests of their choice.

People, and their relatives, knew how to raise concerns and make a complaint if they needed to.

Good

Is the service well-led?
The service was well-led.

There was an open and inclusive atmosphere within the home.

People and their relatives were able to voice their opinions and views about the services they received.

Systems to assess and monitor the quality of the service provided for people were in place and quality checks were carried out regularly.

Good

White Gables

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.

This inspection took place on 6 October 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made our judgements in this report.

We looked at the information we held about the home such as notifications, which are events that happen in the home that the provider is required to tell us about. We also looked at information that had been sent to us by other agencies such as service commissioners and social workers.

We spoke with four people who lived within the home and three relatives who were visiting. We also spoke with the registered manager, a registered nurse, four members of care staff, the cook, the maintenance person and one member of the domestic team.

Some people who lived at the home had difficulties with their memory and were unable to tell us about their experience of living there. In order to help us better understand their experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not speak with us.

We looked at four people's care records. Other information we looked at included; staff recruitment files, supervision and appraisal arrangements and duty rotas. We also looked at records and arrangements for managing complaints and monitoring and assessing the quality of the service provided within the home.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. One person said, "I moved here because I didn't feel safe in the home I used to live in. I feel much safer here." A relative we spoke with told us, "The staff look after the needs of [my loved one] and I would say without hesitation that people are safe here." Another relative said, "I couldn't wish for better care, my [loved one] is safe here."

Staff demonstrated their understanding of the training they had received. The described how they would recognise any potential for abuse and the policy and procedure they would follow in order to quickly report any concerns they might identify. We knew from our records that the registered manager and staff had worked well with other agencies, such as the local authority safeguarding team to address any concerns that had been raised. Records showed, and staff told us, they had received training about how to keep people safe from harm. For example, they had received training about minimising the risk of falls and infection prevention and control.

We saw staff followed the plans for reducing identified risks, such as encouraging people to change their seating positions regularly or assisting people to turn when they were in bed. Care records showed, and staff we spoke with, described a range of possible risks to people's well-being and how the risks were minimised. For example, care plans showed the arrangements in place to assist people who had reduced mobility and for those who were at risk of developing pressure ulcers. Equipment was available to transfer people safely when they bathed and needed support to get into bed. We saw that when using equipment such as hoists, staff explained what was happening throughout the process and made sure people were helped to move around safely.

The provider had a business continuity plan in place in order to make sure people would be safe if, for example, they could not live in the home due to a fire or flood. Staff told us what they would do if there was a fire in order to stay safe. Fire evacuation plans were in place for each person who lived in the home and regular fire drills were in place to make sure people could be evacuated quickly in an emergency.

Staff had been recruited based on checks with the Disclosure and Barring Service (DBS) to ensure they were suitable to work within the home. Staff also underwent checks about their previous employment, their identity and the registered provider had obtained references from previous employers.

The registered manager and staff told us there had been some ongoing staff shortages which meant staff had worked extra hours and additional shifts. A clear recruitment strategy was in place and the registered manager told us they were working with the provider to actively recruit to the vacant posts at the home. As well as staff covering extra shifts the registered manager told us that the registered provider supported them to use agency staff if they needed to.

Staff we spoke with said the registered manager worked to ensure there was enough staff to keep people safe and they worked well together as a team to provide the staff required. Staff worked in small teams within each of the three units and there was a system in place to share care and support duties between the units when short notice staff absences occurred. There was a registered nurse available across each 24 hour period to provide advice and support for people and care staff if required.

The home was clean and tidy. Equipment was stored appropriately so as to avoid tripping hazards. Staff from the housekeeping team demonstrated that they knew about infection control procedures and records showed that all staff within the home had received training about this subject. However, within one area of the home there was an odour. The registered manager and staff told us this was due to a very specific issue. Throughout our visit we saw housekeeping staff cleaned the area thoroughly whenever required and minimised the odour. The registered manager told us about the actions they had taken, including referrals to health professionals, in order to manage the issue. Following our visit the registered manager informed us they had taken further actions, in liaison with social care professionals and the provider, to reduce the impact on the comfort and dignity of everyone who lived in the home.

Arrangements for the storage, administration and disposal of medicines were in line with good practice and national guidance. Those staff who supported people with their medicines told us, and records confirmed, they had received appropriate training to do so in a safe manner. We saw staff stayed with people whilst they took their medicines and only signed for administration when the medicines had been taken. The registered manager and

Good

Is the service safe?

senior staff completed regular audits of the medicines arrangements. Records showed that actions had been taken to address any issues that had been highlighted during audits. The registered manager told us that they were working with a pharmacy professional and local GP's to review all of the medicines used by people who lived in the home.

Good

Is the service effective?

Our findings

When we asked people how staff cared for them they gave us comments such as, “They know how to look after us” and “They do their jobs well.” A relative told us, “It’s a good quality of care here.”

Staff we spoke with told us about their induction and said that it enabled them to do their jobs effectively. One staff member told us the induction programme included shadowing more experienced staff and completing a range of competency checks before they were allowed to provide care to people unsupervised. The programme followed a nationally recognised set of induction standards for social care staff.

Staff also told us they received a range of on-going training to develop skills in line with the needs of the people who lived within the home. For example, training focussed on subjects such as dementia care, helping people to move around safely and providing appropriate nutrition and hydration. The registered manager told us they supported the on-going professional development of staff. Records showed most staff had obtained or were working toward achieving nationally recognised care qualifications.

Staff received regular supervision and appraisals in line with the time scales set out in the registered provider’s policy. The registered manager had planned the sessions across 2015. Staff told us the registered manager and senior staff members were always available for support. They also said supervision sessions helped identify any specific issues regarding their ongoing development and that their knowledge and skills were being continuously developed as a result of the support given. As part of the overall approach to supervision the registered manager confirmed they had a process in place for ensuring regular checks were completed with the registered nurses to ensure their registrations were being maintained and kept updated.

Staff asked people for their consent before they provided support for them. They explained the support they were going to give in a way that people could understand and we saw people responded positively to this approach. People and their relatives told us they were involved in decision making about care needs. One person told us, “Staff respect my wishes.”

Staff were clear in their understanding of how to support people who lacked capacity to make decisions for themselves. They knew about processes for making decisions in people’s best interest and how to support people who were able to make their own decisions. People had assessments and plans in place which related to their capacity to make decisions and best interest meetings were recorded.

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). At the time of our visit 21 people who lived within the home had their freedom restricted and the provider had acted in accordance with DoLS.

People’s healthcare needs were recorded in their care plans and it was clear when they had been seen by healthcare professionals such as community nurses, dentists and opticians. One person told us, “I can see my GP whenever I need to, they help me with that.”

Staff demonstrated their knowledge and understanding of people’s nutritional needs. They followed care plans for issues such as encouraging people to drink enough and weighing people to ensure they maintained a healthy weight. Records for these needs were completed and up to date. They included nationally recognised nutritional assessment tools. Staff we spoke with confirmed that where people were at risk of poor nutritional intake they understood how to make referrals to specialist services. Throughout our inspection we observed the staff team made sure there was always a range of hot and cold drinks available to people at all times to prevent them from getting dehydrated. People also had access to a range of adapted utensils and plate guards in order to help them eat their food independently.

Good

Is the service caring?

Our findings

People and their relatives said they felt the staff were very caring. One person said, "I feel relaxed here and I get on with the staff well." A relative commented, "I feel it's the best home for us. The family always feel welcome because the staff have got to know us and we feel the staff care." Another relative told us, "I watch staff, they're loving and caring. I'm glad [my loved one] is here, I couldn't wish for better care."

Staff spoke with people in a kind, reassuring and caring manner. We watched how staff gently supported a person who had become very distressed about their personal care. They encouraged the person to move to a private area to be supported and gave them reassurance verbally, by holding their hand and giving a gentle hug. The person calmed noticeably with the support from staff.

We noticed staff took time to chat with people and their relatives about day-to-day issues. An example of this was a member of staff who stopped to chat with a person as they were passing. The member of staff asked the person if they could get them anything such as a drink. They chatted about the weather and the person was very relaxed in body language and smiling throughout the contact. The staff member sat at the same level as the person and listened carefully to what the person was saying.

Staff supported people in private with their personal care and made sure they knocked on people's bedroom doors before they entered. When private issues needed to be discussed we saw staff took people to areas where they would not be disturbed or spoke with them in lowered voice tones if the person did not wish to move from where they were.

Staff said they had received support and guidance from the registered manager about how to correctly manage confidential information. They understood the importance of respecting the privacy of people's information and only disclosed it to people such as health and social care professionals when they were required to do so. A relative we spoke with showed us an area in the home which had been designated for people to meet with their visitors in private if they chose to. The relative told us staff always respected their right to privacy in this way.

The registered manager told us they had developed links with local voluntary and professional advocacy services. During our visit a professional advocate (IMCA) visited the home to meet with one person who it had been identified needed this type of support. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. One person told us how they had accessed the service and found it helpful.

We spoke with people and undertook some observations in one of the communal dining areas during the lunch time period. People were coming and going as they chose and staff supported people to have access to their meals and drinks. Staff took time to check that what people wanted matched the menu choices they had made before they were served. One person left their chair half way through eating their meal and became agitated, indicating they had still not been served. A staff member gently responded saying, "Don't worry. Have a seat and relax. Everything will be okay." The staff member gently guided the person from a distance with words and using hand gestures. The person returned to their seat and continued to enjoy and finish their meal.

In another communal dining area people were supported to eat their meal a little later than was usual for them; no more than 20 minutes. Staff from other areas of the home had come to support the meal time as unit staff were busy providing personal care. People told us they were quite happy with the meal times on the day. One person said, "We don't have to sit down for lunch on the button every day."

Staff ensured people's clothing was protected when they were eating in order to promote their dignity. Staff noticed if people wanted more to eat and second helpings were made available if they wanted them. When it was needed staff sat with people to help them eat and took time to give caring, individual support.

Good

Is the service responsive?

Our findings

People's care records identified people's needs, wishes and preferences. We saw staff provided the appropriate support and care described in the records. Care plans had been developed and were reviewed in consultation with people and their relatives. Monitoring charts for needs such as nutrition, pressure area care and continence were completed to show any changes in the person's needs. Reviews of people's care plans were undertaken regularly and records were updated to ensure they reflected what the person wanted and needed.

The registered provider employed two activity co-ordinators who supported people with a range of individual and group activities. Group activities ranged from music afternoons, exercise groups and external visitors from local community groups. The registered manager and one person we spoke with told us about a recent activity which included a visit from a local nature reserve.

A relative told us, "There are a range of things to do here from exercise things, animals outside (chickens and guinea pigs) ball games for hand and eye co-ordination and sing songs. The good thing is these things are not forced on people. They are there if you want them."

We joined one of the co-ordinators who was facilitating an art and craft therapy group in one of the communal areas of the home. One person told us how they enjoyed the sessions saying, "I like to paint." During our observations we saw people were supported to express themselves through the art they were creating and the music playing in the background.

We saw another, more personalised, session taking place in which staff used photographs and their knowledge of the person, to talk about the person's happy memories of days they undertook travelling. The person responded positively to the discussion they had together. The co-ordinator told us, "We try to base our individual activities on the information in the care plans. Each person has a booklet called 'Getting to know you' which people and their relatives fill in to give us that personal picture."

The provider had a complaints policy and procedure in place to enable people to raise concerns. We saw the information was available for people to access easily in the home. People and their relatives told us they felt able to voice any concerns; they were confident they would be listened to and action would be taken to resolve these. One relative said, "The manager and all the staff will help out if I have any issues, they listen to me."

Records showed that when complaints were received the registered manager had followed the provider's policy to ensure the issues were managed appropriately and resolved. They also demonstrated that where necessary the issues had been referred to appropriate external agencies such and the local authority.

Good

Is the service well-led?

Our findings

There was an established registered manager in post and we observed that there was a clear management structure in the home. Staff demonstrated a clear understanding of their roles and responsibilities within the team structure and said the registered manager and senior staff were always available to speak with either direct or by telephone. Staff also confirmed when the registered manager was away from the home management cover arrangements were in place to support them at all times.

We saw that people, relatives and staff freely approached the registered manager and that there was an open and supportive culture within the staff team. The registered manager talked with people who used the service, their relatives and staff throughout the day. They knew them well and had a very good understanding about more detailed areas such as which members of staff were on duty on any particular day. This level of knowledge helped them to effectively oversee the service and provide the leadership the home needed.

People and their relatives told us that the service was well led and managed. A relative we spoke with told us, "The manager has worked with us all along the way. They understand our individual situation and we feel the support and understanding we have had from the manager has been second to none."

Staff we spoke with told us the registered manager always listened to their views and they had a chance to say what they thought about things at any time because the registered manager was easy to access and had an open door approach. We saw the provider had a staff incentive sheme in place called the 'Kindness in Care Award'. This enabled people, any visitors to the home or other staff members to nominate staff who's actions had stood out to them as examples of good quality care. One staff member said they liked the scheme because it was always nice to know when people appreciated they work they did.

Regular meetings were held with staff in all of the job roles within the home including care staff, housekeeping staff and maintenance staff. This meant that information could be shared effectively across the team. Records of the meetings showed subjects such as feedback from surveys, progress with action plans and safety alerts were discussed. One staff member told us, "Communications are good. We meet at least every two months."

Staff demonstrated they were aware of whistleblowing procedures and said they would not hesitate to use them if they needed to. Staff said they had access to the numbers they needed to raise any of these types of concerns, including the contact details for The Care Quality Commission.

The registered manager had made sure we were informed about any untoward incidents or events within the home in line with their responsibilities under The Health and Social Care Act 2008 and associated regulations. However, although the registered manager had informed us when they had referred people for assessment under DoLS arrangements, they had not informed us of the outcomes. The registered manager said this had been an oversight and took action during the visit to submit the information to us.

Records showed that incidents and events were analysed and learned from. As a result of the learning we saw changes were made to people's care to reduce the risks of incidents and events happening again, such as, bedroom furniture being repositioned, alarmed foot mats being used and bed rails being fitted.

There was a range of processes in place which enabled the provider and registered manager to receive feedback on the quality of care provided at the home, including annual satisfaction surveys for people who lived within the home, their relatives and staff. We saw comment cards were available in the reception area of the home. Information on the cards included who to contact if any issues or concerns needed to be discussed direct. We also saw a new system had been introduced using an electronic tablet device. This was located in the reception area of the home. The registered manager told us visitors could tap in any comments or confidential feedback they wanted to share and that this would go straight to the provider so it could be reviewed and any actions taken.

There were quality assurance systems in place that monitored care. There were regular visits from the provider's representatives who reviewed the quality indicators and monitored how the service was performing. Where any issues had been identified for improvement

Good

Is the service well-led?

there were actions put in place by the registered manager to address these. However on the day of our visit the system in place to share care and support duties between the units when short notice staff absences occurred was not fully followed. This meant that staff in one unit had an increased workload. We saw that people who lived within the unit had all of their care and support needs met although they were supported to eat lunch a little later than was usual for them. The registered manager acknowledged that the system had not been fully implemented on the day of the inspection and said they would review the arrangements with the staff team. Following our visit the registered manager confirmed they had done this.