Whitegates Care Centre Limited

# Whitegates Care Centre Limited

## Inspection report

1 Condor Road
Laleham
Staines-upon-thames
TW18 1UG

Tel: 01784441287
Website: www.chdliving.co.uk

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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

Whitegates Care Centre Limited is a care home with nursing for a maximum of 51 people, including people with physical disability, sensory impairment, and people living with dementia. There were 50 people living at the home at the time of our inspection.

People's experience of using this service:
Where risks had been identified to people's health and wellbeing, measures had not always been implemented to mitigate these. For example, pressure-relieving mattresses designed to reduce the risk of people developing pressure ulcers were not always set correctly. People's medicines were not always managed safely.

Governance systems were not always effective in identifying shortfalls. For example, medicines audits had not identified the concerns we found in relation to medicines management. Guidance for staff about the care people needed and records of the care people received were held on a number of different systems, which meant we could not be assured people were receiving safe and effective care. Some guidelines about people's care was inconsistent or lacking in clarity, which meant we could not be sure people were being supported in a consistent way.

The provider had an arrangement with the local health trust to admit people being discharged from hospital when they were fit for discharge. This was called the Discharge to Assess scheme. People were admitted to the home with the aim of having a short stay before returning to their own homes or moving to another care setting. The hospital had a responsibility to provide information to the home about people's needs and the care they required before they were discharged.

Managing admissions under the scheme presented challenges for the home, as information provided by the hospital was sometimes inaccurate or insufficient for staff to plan their care. Additional challenges were presented by poor communication from the hospital, frequent changes of plan, and people being discharged to the home without the correct medicines. The provider recognised the pressure this placed on the home and had scheduled a meeting with the hospital and the local authority to discuss their concerns and ways in which the scheme could be coordinated safely and effectively.

There were enough staff on duty to meet people's needs. Staff were recruited safely and understood their role in safeguarding people from abuse. The home was clean and hygienic, and people were protected from the risk of infection.

People who lived at the home and their relatives had opportunities to give their views and these were acted upon. Relatives told us communication with them from the home was good. Staff received good support from the management team and worked well together as a team.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 7 July 2021).

Why we inspected
We received safeguarding concerns in relation to the quality of information held about people needs and the care they required and the potential impact of this on people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 COVID-19 and other infection outbreaks effectively.

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.

You can see what action we have asked the provider to take at the end of this full report.

We shared feedback about our findings with the provider at the end of our inspection. The following day, the provider sent us details of how they planned to address the shortfalls we had identified.

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

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?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-led findings below.

# Whitegates Care Centre Limited

**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 Health and Social Care Act 2008.

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
The inspection was carried out by 2 inspectors and a specialist nursing advisor.

Service and service type
Whitegates Care Centre Limited is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Whitegates Care Centre Limited is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

Before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return in February 2023. 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 used all this information to plan our inspection.

During the inspection
We spoke with 5 people who lived at the home and 3 visiting relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the deputy manager, the provider's regional manager, 2 nurses, 2 team leaders, 3 care assistants and the activities co-ordinator.

We looked at care records for 7 people, including their assessments, care plans and risk assessments. We checked records of accidents and incidents, 4 staff recruitment files, quality checks and audits, and the arrangements for managing medicines.

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 good. At this inspection this key question has changed to requires improvement. 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; Learning lessons when things go wrong

- Risks to people were not always managed effectively. Some people used pressure-relieving mattresses to reduce the risk of developing pressure ulcers. These need to be set according to the weight of the individual to function effectively. In some cases, the settings were incorrect as they did not correspond to the weight of the person using them. For example, 1 person whose weight was recorded as 48.2kg had a mattress set at 150kg. Another person whose weight was recorded as 73.35kg had a mattress set at 180kg. this meant people were not adequately protected from the risk of developing pressure ulcers.
- We saw evidence that staff checked pressure mattress settings on a regular basis. However, where staff had recorded that mattresses were set incorrectly, no action had been taken to correct the settings.

Risks to people's health and wellbeing were not managed effectively, which 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.

We shared this concern with the provider during the inspection. In response, the provider took immediate action to correct pressure mattress settings and told us they would implement daily checks by a team leader to ensure all mattresses were set correctly.

- Assessments had been carried out to identify any potential risks to people, including the risks associated with mobility, continence, and eating and drinking. Where risks were identified in these areas, measures were put in place to mitigate them. For example, sensor mats had been installed in the bedrooms of people identified as at risk of falling when alone.
- Any accidents or incidents that occurred were recorded. The registered manager maintained and reviewed an accident and incident spreadsheet to identify any emerging themes.
- Lessons were learned through investigations of incidents and action taken to prevent similar events happening again.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● People who lived at the home permanently had been asked to give consent to their care and any treatment they received. If people lacked capacity to give informed consent, mental capacity assessments had been completed and relevant people consulted to ensure decisions were made in people's best interests.
● The hospital from which people were admitted under the Discharge to Assess scheme had not provided evidence of people's consent to move to the home or that, where necessary, a best interests decision-making process had been followed. The provider had contacted the hospital discharge team to advise that admissions to the home under the scheme would only be accepted if accompanied by evidence of people's consent to move or of a mental capacity assessment and best interests decision.

Using medicines safely
● Medicines were not always managed safely. There were gaps in some people's medicines administration records, which meant we could not be assured people had received their medicines as prescribed. The allergy section on people's medicines administration records was not always completed and medicines administration records did not always contain a photograph of the person. Some hand-written entries on medicines administration records were not signed.
● There were no protocols in place for some medicines prescribed 'as and when required' (PRN), which meant there was no guidance for staff about when these medicines should be administered.
● One person's medicine was administered covertly (without their knowledge) in the form of a crushed tablet given with food. A GP had approved this but there was no evidence a pharmacist had been consulted to establish whether the medicine was suitable to be administered in this way.
● A nurse had signed to record topical creams had been administered. However, the nurse had not been responsible for administering the creams; this had been carried out by care staff. Body maps were not always maintained to record the administration of topical creams.

People's medicines were not managed safely, which placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared this concern in feedback with the provider at the end of our inspection. In response, the provider told us they would implement daily checks of medicines administration records and add photographs to these where needed, update allergy information and PRN protocols, and ensure any hand-written medicines administration records were double-signed.

● There were safe and effective systems for the ordering, storage, and disposal of medicines. Nurses were responsible for ordering medicines but team leaders were also receiving training so they could assist with this process.
● Medicines were stored securely. The temperatures in clinical rooms and fridges used to store medicines were checked and recorded daily and were always within the acceptable range.
● Controlled drugs were stored appropriately with the required documentation in place and completed correctly. Liquid medicines had dates of opening on the bottle to ensure it was not given beyond the safe date. Unused medicines were disposed of appropriately with documentation in place.

Staffing and recruitment

● There were enough staff on duty to meet people's needs, including people who needed one-to-one support. People told us staff were available when they needed them. People able to use call bells told us staff responded quickly when they used them, and we saw evidence of this. The relatives we spoke with said staffing levels were good and staff confirmed this. There were enough staff to support people at lunchtime, including people who needed support to eat in their rooms.

● There were vacancies on the permanent staff team which the provider used agency staff to cover. The provider mitigated the impact of this on people's care by using the same agency staff regularly. One person told us, "They use a lot of agency people, but even then you see the same faces. There is not really a difference between agency and permanent [staff]; they are all pretty good, really." A relative said, "I am very impressed with the staff. Agency [staff] maybe wear different uniform but we see no difference."

● All but 1 of the agency staff we spoke with on the day of our inspection had worked at the home for some time. The provider was actively recruiting more permanent staff and had recently offered posts to a number of applicants.

● The provider's recruitment procedures helped ensure only suitable staff were employed. The provider obtained proof of identity and address, references and a Disclosure and Barring Service (DBS) check in respect of staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Staff attended safeguarding training and were able to describe the signs of potential abuse. Staff knew how to report abuse or poor practice, including how to escalate concerns with external agencies if necessary. One member of staff told us, "We have [safeguarding] training with our agency. Any concerns, I would report to the nurse or a team leader. I know I could also report to the [local authority] safeguarding team if I had to."

● When safeguarding concerns had been raised, the provider had cooperated with the local authority to investigate these concerns and contributed to safeguarding enquiries when requested to do so.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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 were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 good. At this inspection this key question has changed to requires improvement. This meant governance, care planning and recording systems did not always assure high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care

- The home was in the process of introducing a new digital care planning and recording system. We found some information was recorded on the new system, some on the existing system, and some on paper-based records. This meant it was not always clear what care staff should be providing and not possible to be assured the care people should be receiving was being provided.
- The information held about some people's needs on the different systems was inconsistent, which presented a risk people would not receive care and treatment according to their wishes. For example, one person's care records on the new care planning system said they were for resuscitation in the event of an emergency in which they stopped breathing or their heart stopped beating, but the person's medicines administration record was accompanied by a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) form.
- Some guidelines about the care people needed lacked clarity, which presented a risk people would not receive care and treatment according to their individual needs. For example, care plans for people who had diabetes were not always clear about what blood glucose level would constitute hypoglycaemia or hyperglycaemia.
- Quality assurance systems were not always effective in identifying shortfalls. For example, medicines audits were carried out monthly but had not identified the issues we found with medicines management. Staff carrying out the audits had answered 'Yes' to questions where we found evidence to the contrary, including whether protocols were in place for all PRN medications, allergies were clearly recorded on medicines administration records, and hand-written medicines administration records were signed by 2 people.

Records were insufficient to ensure people always received the care they needed. Quality monitoring systems were not effective in identifying shortfalls. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared this concern in feedback with the provider at the end of our inspection. In response, the provider told us they would complete the transitioning of all care plans to the new digital records system by the end of March 2023 and that the registered manager would take responsibility for the completion of quality

audits.

● The registered manager was aware of their responsibility under the duty of candour, including being open and honest if errors occurred. Notifications of significant events had been submitted to CQC when required.

Working in partnership with others

● Managing admissions under the Discharge to Assess scheme presented challenges to the home, as the information provided by the hospital about people's needs was sometimes inaccurate or insufficient for staff at the home to plan their care effectively. For example, we noted from accident and incident records that one person discharged under the scheme presented a risk to themselves and others due to their behaviours. However, the home had not been informed about this risk prior to admission and had therefore not had the opportunity to put plans in place to manage it.

● A further challenge was presented by poor communication from the hospital, or frequent changes of plan. Some people were not discharged from hospital on the day the home had been told to expect them. On other days, 2 people were discharged from hospital to the home, when the provider's agreement with the hospital stipulated there should be no more than one discharge each day to enable the home to manage the admission effectively.

● Poor communication from the hospital with the families of people discharged under the scheme had presented difficulties for the home in establishing positive relationships with people's families. For example, some people had been discharged to the home without the hospital informing their families, or providing them with information about how the scheme worked. This meant the home experienced understandable frustration from people's families at how their family members' discharges had been managed.

● The provider recognised these challenges and had implemented measures to address them, such as basing a member of staff in the hospital to coordinate discharges. However, we heard from staff that pressure from the hospital to arrange discharges meant these measures had not been entirely effective. The provider had scheduled a meeting with the hospital and the local authority for 5 April 2023 to discuss their concerns and ways in which the scheme could be coordinated more effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were encouraged to give their views about the care they received, the food, activities and any other issues they wished to raise. People said their feedback was listened to and acted upon.

● Relatives told us communication from the management team was good and they could access any information they needed. One relative said, "The manager is lovely, very cooperative and communicative. After [family member] came out of hospital, she rang me regarding his blood tests and told me what they had done."

● Some families of people admitted under the Discharge to Assess scheme had told the provider they had not been given sufficient information about how the scheme worked before their loved ones had been discharged from hospital. In response to this feedback, the regional manager had developed a user guide for people admitted under the scheme which explained the aims, objectives and practicalities of the scheme.

● Relatives told us staff kept them up to date about their family members' well-being and any events affecting their welfare. One relative said of staff, "They are friendly, helpful, and approachable. They keep us up to date with how [family member] is doing and are happy to answer any questions we have."

● Relatives told us family meetings were useful opportunities to hear about developments at the home and to give their feedback. One relative said, "I have attended a couple of relatives' meetings. We were told about staffing issues, we talked about the food; there were opportunities to give feedback."

● Staff told us they received good support from the management team and senior staff. They said advice and support was available to them when they needed it. One member of staff said, "[Registered manager] is

very supportive and will help me in any way she can. [Regional manager] is very down to earth and approachable."

● Staff told us they supported one another and worked well together as a team. Agency staff said permanent staff had helped them understand people's needs and kept them up to date if people's needs changed. A member of agency staff told us, "All the [permanent] staff are very helpful here. They helped me get to know people in my induction and they tell us at the start of the shift about any changes [in people's needs]."

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure people's care was provided in a safe way, or that medicines were managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to effectively assess, monitor and mitigate the risks relating to people's health, safety and welfare. |