Care Quality Commission

Whitegates Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Whitegates Care Centre Limited is a care home providing personal and nursing care to up to 51 people aged 65 and over. At the time of the inspection 32 people lived in the home and received support and care due to their physical and health support needs. Some people also lived with dementia.

People's experience of using this service and what we found
People and their relatives told us the home was safe and they felt staff provided good care and knew people's needs well. Staff regularly reviewed people's individual risks and protected them from avoidable harm. Staff also worked with other healthcare professionals where needed to ensure people's health and care needs were appropriately addressed.

The home manager recently reviewed staff deployment and made sure there were enough staff on duty, so people received timely care meeting their needs. The provider followed safe recruitment practice to safeguard people.

Staff demonstrated good infection and prevention practice which protected people from spread of infections, including COVID-19. People received safe support with their medicines.

The home manager had a good oversight of the quality and safety of care and was supported by the provider to improve the service. There was a robust service improvement plan in place, and we saw actions were progressed as planned. For example, people's hydration needs were now closely monitored, and staff were aware how to support people to have regular drinks.

Staff felt supported to raise any concerns and were complimentary about the manager and the regional manager. The manager improved communication within the staff team by implementing clear structures for discussions and gathering staff's feedback. People's relatives felt informed and involved in the service. They were able to visit their loved ones and spend time together in the community in COVID-19 secure way.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 4 March 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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 carried out an unannounced comprehensive inspection of this service on 30 January 2020. A breach of regulation 12 (Safe care and treatment) legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.
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 continue to monitor information we receive about the service until we 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 safe. Details are in our safe findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

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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
The inspection was carried out by two inspectors.

Service and service type
Whitegates Care Centre Limited 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. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, there was a home manager in charge of the day to day running of the home who was in the process of applying for CQC registration.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with 10 members of staff including housekeeping and maintenance staff, healthcare assistants, registered nurse, home manager, regional manager and quality and compliance manager. We reviewed a range of records. This included medicines records for four people and daily care records for five people. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality and safety audits, accident and incident records and policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training data, COVID-19 risk assessment, additional meeting records and risk management plans for five people. We spoke with five relatives of people who received care and one more registered nurse working in the home.

Good

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 now improved to good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risk had been managed in relation to fluids provided to people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● At the last inspection we found not all people had access to fresh drinks and staff had failed to monitor their fluid intake where it had posed a risk of dehydration or infections. At this inspection we saw all people had fresh drinks available to them. One relative said, "They encourage fluids and I know that they write [fluid intake] down. [Relative] was losing weight so they encourage her to eat and they give her [nutritional supplement]. Given her age and frailty, they do remarkably well."
● The provider implemented new fluid monitoring charts. Staff were aware of people's risks and recorded where support was offered with drinks. There was clear guidance for staff on how much people should drink every day and registered nurses monitored that daily. Records confirmed people now received regular support and the risk of dehydration was well managed.
● People's relatives told us staff supported their loved ones to address any individual risks. One relative said her family member was at risk of skin damage but did not have any problems for some time as staff spotted any redness quickly and, "They treated it immediately and it was resolved." People's records included appropriate individual risk assessments, for example around COVID-19, falls risk, specific health conditions such as diabetes, continence and skin integrity.
● Staff we spoke with were aware of people's individual risks. For example, staff told us how they needed to regularly check on some people who spent the majority of their time in bed and were not able to call to summon help. Records confirmed people with complex needs were offered regular support around their day to day needs and we observed some kind, positive interactions between people and staff when they were provided with support.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with and their relatives told us they felt the home was safe. One relative said, "They have been spot on with protecting all the residents, which is the main thing."
● Staff knew how to protect people from abuse and neglect and felt confident in how to report any concerns. One staff member said, "First I would go to [manager]. If I didn't feel I was being listened to, I would do the whistle-blowing." Staff also received safeguarding training.
● The manager reviewed all incidents and accidents and reported any safeguarding concerns to the local authority where needed. They were also working together with social services to ensure action was taken to

protect people. The management team undertook additional work to promote a culture of openness and 'speaking up' in the service and were supported by the provider's HR department.

Staffing and recruitment
● There were enough staff to provide people with the care they required. Although the home was a busy service, we saw staff were present and able to attend to people's needs in a timely and safe way and people's records confirmed that. People we spoke with told us they were confident they would receive support when needed. One relative said, "There are always enough people around in the right place."; and explained this meant the home did not feel institutional to them but same time people were kept safe.
● The manager made changes to the daily staff deployment plans to ensure staff were able to safely assist all people they took care of in a timely way during the day. One staff said, "It can feel very busy but it's fine as long as you manage your time well." Staff commented there were some days when the home got busy, especially if there were multiple emergencies but they would receive support from the manager to safely manage those situations.
● The manager followed safe recruitment practices. Hence, only suitable staff were employed. The provider obtained proof of identity, references and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions and include a criminal record check.

Using medicines safely
● People's relatives told us they had no concerns around support their loved ones received with their medicines. People were supported by trained registered nurses who were aware of individual risks and specific needs. For example, there was clear guidance in place for management of diabetes or use of additional medicines for people at the end stages of their lives.
● Staff completed medicines administration records (MAR). Additional guidance, for example on medicines interactions was available for nurses in the clinical rooms. There were clear protocols in place for 'when required' medicines or topical medicines such as creams.
● Staff performed regular checks of medicines stock and storage. For example, due to hot weather on the day of the inspection, the registered nurse took immediate action to call for assistance of the maintenance staff to cool down the room, so the medicines were kept safe.
● The provider had an auditing system in place for safe management of medicines and appropriately reported and managed any medicine errors when needed. This included not only errors in administration, but also recording errors. Records confirmed the manager took appropriate action to investigate the cause of the error and addressed lessons learned to prevent similar occurrences in the future.

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 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.
● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. Staff had access to appropriate PPE and used it correctly when supporting people. However, we

observed not all staff members had well-fitting face masks throughout our visit when not providing care. The provider addressed this with staff and continued to support them around PPE use. There was an allocated IPC lead for the service and additional training was booked for staff. There was no PPE station near the exit to the staff smoking area which we addressed with the provider. The home manager immediately actioned our feedback and placed PPE supply station near the door to ensure staff could appropriately dispose of their face mask before going for a break and put on a fresh mask on their return. We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● The home manager had systems in place to routinely analyse incidents, accidents and individual changes in people's needs and addressed any lessons learned to prevent ongoing risks to people. They were supported to improve this area of practice by the regional manager who regularly visited the service.
● Incidents and accidents such as falls were logged and checked for any underlying causes to establish ways of supporting people to minimise risks to people. For example, records showed for some people staff increased the frequency of the welfare checks to ensure support was readily available. For others, additional equipment was put in place such as sensor mats.
● The manager implemented a new meeting structure and outline which included regular discussions about lessons learned and follow up action required to protect people. Records confirmed clinical staff reflected on incidents and accidents and lessons learned and changes were made to people's support when needed.

Good

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 requires improvement. At this inspection this key question has now improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted 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

At our last inspection we recommended that the provider ensure checks are in place to ensure quality is being maintained with fluid charts and the recording of information by staff. The provider had made improvements.

● The provider improved the systems of recording people's fluid intake and monitoring people's health risks since our last inspection. Recording charts were changed and guided staff better on how much people should drink to remain well-hydrated as individual targets were identified for people in consultation with their GP. Staff knew people who would be at risk without support to drink throughout the day and their individual risks were discussed during various staff meetings, including staff meetings and clinical review meetings.
● The registered nurses now monitored people's overall fluid intake daily. The staff team also completed daily monitoring charts to ensure all people had fresh drinks available in their rooms. The home manager had a good oversight of people's changing needs as they regularly communicated with the staff team and provided 'hands on' leadership for staff.
● The provider supported the manager to undertake a range of quality and safety audits. These were followed by a creation of a robust service improvement plan for the home. We saw improvements were being completed as planned. For example, communication within the staff team was improved by implementation of clear schedules and agendas for staff meetings, clinical review meetings and daily 'flash meetings. Healthcare assistants were invited to the daily meetings with the manager alongside clinical staff and heads of departments.
● The senior staff regularly reviewed people's individual risks such as risk of falls, malnutrition or wound care needs. People's records confirmed staff took action to modify their care to address any changing needs. For example, we saw the number of people at high risk of malnutrition decreased since April 2021 and people's wounds were healing.
● The provider supported the home manager to ensure any events which had to be reported to CQC were notified appropriately.

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

● People and their relatives told us the home atmosphere was inclusive and welcoming. One relative said, "As soon as you walk in, there is a really nice vibe. We thought [relative] would feel comfortable [in the home] and that has proved to be the case."
● The leadership in the service promoted a positive, open and supportive culture in the home. The regional manager said the priority was, "Talking to each other, questioning each other and feeling safe to do that." Staff we spoke with confirmed this was the case. One staff member said, "We can go to [manager] with any issues and she does try her best to deal with it. She is very nice and approachable."
● The changes made to the day to day running of the home and communication systems positively impacted on the care people received. One person said, "They have been very good to me here. They have got me walking again. I don't want to go [to my previous house], I like it so much here." One relative also commented, "Even the people who are not employed directly in caring roles are very caring."
● The home manager was aware of their duty to be open and transparent. The provider supported the manager to ensure their duty of candour was met when responding to any incidents, accidents or complaints. People's relatives were contacted when needed. One relative said, "They have always reported any concerns."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The staff team effectively engaged people and their relatives. One person told us they were consulted and felt well-informed about the COVID-19 precautions in place before moving into the home. A relative told us, "[Staff] were great. We would phone up and they would report back to us on how [the person] was and as soon as they could, they arranged a Facetime call. They did that quite quickly and that was really nice."
● Staff felt listened to and encouraged to express their comments and suggestions. One member of staff said, "We are having more staff meetings now, which is good. [Manager] asks us if we have got any issues or concerns. We have got a big one today with all of us. We can air our grievances if we've got any. We didn't have many of them before but since [manager] has taken over, we have had them regular."
● The service worked in partnership with other healthcare professionals such as GP, tissue viability nurses, podiatrist or community mental health team. The provider had good working links with the local authority, local care association and other organisations in the area.