

Whitegates Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Whitegates Care Centre is a 'care home' providing personal and nursing care for up to 51 people. At the time of our inspection 40 people were living at the service, a number of whom were living with dementia.

People's experience of using this service and what we found

People told us they felt safe living at the home. We observed that people were kept safe as most staff knew people and understood their needs. The service did use a number of agency staff and had been open and honest about recruitment problems. Some people felt the use of agency staff had some effect on the continuity of care. We have issued a recommendation.

People's medicines were stored and administered safely, and infection control practices were followed. Staff understood how to protect people from harm and knew when to report any abuse. People's risks were identified, and staff acted to address any known risks. Appropriate recruitment checks were carried out to ensure staff were suitable to support people in the home. Incidents and accidents were recorded and analysed for any trends to prevent future incidents such as falls.

People were supported to maintain good health and they had access to relevant healthcare professionals when they needed them. People received good care around any pressure sores or wound care and staff followed advice given by the nurses or healthcare professionals.

People had a varied and balanced diet and said they enjoyed the food. Staff were knowledgeable about people's likes, dislikes and allergies with food.

We identified a concern around levels of fluid being provided to people in their rooms. On a few occasions daily fluid charts had gaps in recording which meant it appeared that those people had less fluid each day than the total amount needed or recommended for them. We did not observe any direct incidents of dehydration on the day of inspection. We did observe one person who had two jugs of water from the previous two days and no fresh water for the day in their room. The registered manager sent us examples of fluid being recorded following the inspection to show this concern had been acted on. We have issued a breach of regulation around this concern.

People told us they were supported by caring staff that respected their equality, diversity and privacy. Staff also supported people to be independent and achieve goals. People were supported by staff to have access to health and social care professionals.

People had access to a variety of daily activities. Staff also conducted one to one sessions with people who chose not to take part or who were cared for in bed. People also had the opportunity to go out into the community either as a leisure activity with staff or a personal trip with family.

There was a complaints procedure in place for management to investigate any concerns and implement measures to prevent any future incidents.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We identified some shortfalls with the quality of the audit process. Despite previous issues being raised with the recording of fluids, quality checks had failed to ensure improvements had been maintained to identify gaps in recording for people's daily fluids which we identified on inspection. We have made a recommendation for the provider to ensure quality checks are consistent.

People, relatives and staff told us that overall, they were happy with the management of the service. Feedback received for the service from relatives and healthcare professionals had been positive.

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 02 February 2019). Since this rating was awarded the provider has altered its legal entity. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This was a planned inspection based on the previous rating.

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 not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team

Three inspectors, a specialist nursing advisor and an expert by experience carried out the inspection. 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

Whitegates Care Centre Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not at the home on the day of inspection. We were supported during the inspection by the home's deputy manager and regional manager.

Notice of inspection

This inspection was unannounced.

Before the inspection

We did not ask the provider to complete a provider information return (PIR). 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.

We reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law.

During the inspection

We spoke with eight people who lived at the home, six relatives and one visiting professional. We spoke with eight staff including the regional manager, the deputy manager, the chef, care staff and housekeeping staff.

We looked at care records for six people, including their assessments, care plans and risk assessments. We checked six staff files, medicines management and recording, accident and incident records, quality monitoring checks and audits.

After the inspection

The registered manager sent us further information by email as they were not present on the day of inspection. We liaised with the registered manager to obtain information relating to the day of inspection.

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 good. At this inspection this key question has deteriorated to requires improvement.

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

- People who were cared for in bed did not always have enough to drink. One person who was required to have their fluid intake monitored was observed by us to have two jugs of water dated for the previous two days. They did not have a jug of water for the current day, which meant they did not have any fresh water available to them in their room. A relative told us they felt [person] had become dehydrated. This was raised with the nurse who apologised to the family and obtained a fresh jug of water.
- Food and fluid charts had not been consistently filled in leaving people at risk of dehydration. Three people's fluid charts had gaps in recording how much people had drunk during the day. There were no clear totals set for people or a consistent record of how much a person had to drink which meant staff did not know if they needed to encourage people to drink more to avoid dehydration. This was raised with the nurse who agreed the fluid charts should be filled in better by staff and that they had constantly reminded staff about ensuring they were filled in.
- Following the inspection, the registered manager sent us examples of fluid charts that had been completed for a period of four days after the inspection. This offered assurances that people were no longer at risk of dehydration. We will check at the next inspection this has been maintained.

The failure to ensure risk had been managed in relation to fluids provided to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In other areas risk assessments were up to date and reviewed when required. Staff had a good understanding of people's risk and knew how to mitigate them. For example, one person was at risk of sore skin, staff ensured they consistently had the correct pressure relief available. Staff had a good knowledge of why this was needed, and the information was clearly recorded.
- Fire doors and systems were regularly checked to ensure they were in good working order. Regular fire drills took place. People have individual personal evacuation plans (PEEPS) which detailed the evacuation procedure based on each person's needs.
- Utilities and equipment were regularly checked and serviced to make sure they were safe to use. This included hoists, wheelchairs, adapted baths and fire extinguishers.

Staffing and recruitment

- People were positive about the way staff supported them. However, people felt there was a lack of continuity with staff due to the use of different agency staff. A person told us, "We are having a lot of changes

at the moment with all the agency staff. I like to have the same ones if possible. That's the main thing." A staff member told us, "It does affect things [use of agency staff] because there is no continuity of care."

- The regional manager and nominated individual had been open and honest about the difficulties they had with recruiting additional permanent staff. Incentives had been offered to staff such as accommodation support, financial rewards for continued employment and progression to senior roles to encourage staff.
- The provider used a dependency tool to ensure safe levels of staff had been used. We checked staffing rota's which indicated staffing levels had been maintained at a safe level to be able to meet people's needs. We observed on the day of inspection that people were seen in a timely manner by staff when they asked or pressed their call bells.
- People's dependency levels were regularly reviewed and recorded to ensure staffing had been based on accurate up to date information. We observed this had been recorded within people's electronic care files.
- Overall staff felt they worked well as a team and there were enough on duty to meet people's needs. However, certain times of the day staff said were busier and additional staff would help. One staff member told us, "Yes, enough staff, we know everyone and their needs." Another staff member told us, "If you work as a team, yes, but it can be a problem in the morning because everybody wants to get up at the same time."
- Staff were recruited safely. This meant people were supported by staff who were of good character and suitable to work in a care setting. Checks were done on applicants before they were offered employment. These checks included checks with the Disclosure and Barring Service (DBS). The DBS inform potential employers of any previous convictions or cautions a person has.

We recommend the provider considers the use of regular agency staff where possible to help ensure continuity of care.

Systems and processes to safeguard people from the risk of abuse

- Staff received safeguarding training and had access to a whistle blowing policy. A staff member told us, "I have attended safeguarding training. I would report anything to the manager and there are numbers to call for the local council if I need to report it further."
- Staff knew how to safeguard people from abuse and were confident to raise any concerns they had. The provider had an up-to-date safeguarding policy in place.

Using medicines safely

- People received their medicine on time by staff who were trained to administer it as prescribed. Staff administered medicines discreetly and explained to people what each medicine was for and the importance of taking it.
- Prescribed creams were used as directed and there was guidance on their administration available for staff. Medicine was stored securely and in line with manufacturer's instructions.
- Medication administration records (MARs) were in place and had been fully completed. We checked seven MAR charts, and all had been completed correctly with no gaps and captured the required information so that the medicines could be administered to people safely. MAR charts had also been checked daily by a nurse to ensure accuracy was maintained.
- People who received their medicines covertly (without their knowledge of consent) had guidance in place to assist staff. Covert medication forms had been signed by a GP and Pharmacist.

Preventing and controlling infection

- People told us the home was kept clean, and regular checks were carried out to ensure the cleanliness was maintained. A person told us, "They clean it every day." A relative told us, "It's always clean and tidy when I visit, there are always people around the home cleaning, they do seem to take pride in it."
- People were protected from the risk of infection by effective infection control procedures being in place.

The provider employed domestic staff who worked in the home and maintained a clean and tidy home.

- Staff received infection control and food hygiene training. They had access to personal protective equipment such as disposable gloves and aprons, and cleaning materials. We observed staff using protective equipment throughout the day. We also observed staff washing their hands having assisted a person with personal care.

Learning lessons when things go wrong

- The provider had a system in place to check incidents and understood how to use them as learning opportunities to try and prevent future occurrences. The regional manager told us that the registered manager would complete a review and identify any action points. This would then be followed up by the regional manager who said, "[The registered manager] is very good and on top of things. Usually when I call to ask about any incident she has already actioned it and provided an outcome."
- The regional manager told us they had learned lessons and developed actions around the management of falls. For example, one person who had several falls in a month was referred to the GP for further investigation. Their medication was reviewed and changed which stopped the falls from happening. We also saw evidence that people been seen by the falls team. People had crash or sensor mats in place as they had been identified as being at risk of falls.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

Good: This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

- People said they enjoyed meal times. One person told us, "The food is lovely. The chef cooks it perfectly." Another person told us, "The food is excellent. It is always nicely presented and edible."

- People were offered choices with their meals. We observed people in the dining room and people in their rooms being shown show plates of food, so they could make a choice with the options presented to them. We observed staff speaking to people about the food to take on board people's views and opinions which assisted to create happy lunch environment.

- Both care staff and kitchen staff were aware of people's dietary needs. There were good levels of communication between staff to ensure people's preferences were adhered to. One staff member stated to the kitchen staff that [person] enjoys a lot of extra sauce on their lunch. The carer told us that having the extra sauce encouraged the person to eat more and maintain a healthy weight.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered manager and/or deputy manager met each person before they moved into the service. This was to establish the care needed and to ensure the service could meet the person's needs.

- Care plans showed people's needs had been assessed and planned for. Guidance and direction were provided for staff on how to meet those needs. Staff used nationally recognised tools to assess nutritional risks, pressure ulcers and falls risks.

- Care plans were reviewed monthly. This meant the person's assessment, care, support plan, wishes and choices were re-visited and updated.

Staff support: induction, training, skills and experience

- When staff started working at the service they underwent an induction. This process included showing them around the service, fire procedures, health and safety requirements and reading people's individual support plans.

- Staff had completed mandatory training. This included training in areas such as safeguarding, mental capacity, infection control, equality and diversity, dementia awareness, nutrition and hydration and moving and handling.

- Staff felt that although they had completed mandatory training they felt they needed some additional training to manage challenging behaviours. Staff told us they support people in the home who have displayed challenging behaviour and they would like more support on how to deal with those situations. A staff member told us, "I have been hit [by person] before. I'd like more training on how to support that

person." The regional manager told us that staff had completed the mandatory dementia awareness training and now in addition, to support staff, extra training had been booked for staff to receive 'Dementia/Communication – Distress Awareness' training'.

- Staff had received regular supervision with the management team. This enabled staff to have dedicated time to discuss anything they required with a senior manager. A staff member told us, "I think it's every six to eight weeks {supervisions}. I find these useful. "The good thing with [Deputy Manager] is that she is very approachable, and she does listen."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The provider had clear systems and processes for referring people to external services. This allowed effective information sharing and continuity of care. Where referrals were needed, this was done in a timely manner. For example, we saw from people's records they had access to GP, dental and mental health services as and when required.
- People were supported to receive coordinated care when they used or moved between different services. This included nurses passing on important information when a person was admitted to hospital.
- People were supported by staff to maintain good oral hygiene. People had an oral healthcare assessment which was regularly reviewed and updated within their care plan. People had been referred to a dentist as and when any further treatment or support was required. One person had a note in their assessment to state lip balm should be applied if they had a dry mouth. We saw from this person's daily notes that staff had been ensuring this was done.
- Professionals complimented staff and told us staff followed their advice and sought further guidance when needed. One professional told us, "When I come here I do get welcomed. They can give me a copy of the care plan and the risk assessments. From my point of view there is a warm welcome and staff appear to know what they are doing."

Adapting service, design, decoration to meet people's needs

- The premises and environment were designed and adapted to meet people's needs. Corridors were wide enough for easy wheelchair access. There was an improvement plan in place to enhance the accommodation and communal areas. For example, corridor areas and lounges had recently been painted. The provider had recognised areas where old furniture needed replacing.
- There were adaptations to support people's needs such as clear signage to identify key areas for people living with dementia. Further improvements had been identified to improve the experience for people living with dementia.
- People's rooms had been decorated and made personal to them. We saw that people had personalised their rooms with things that meant something to them such as pictures of family members. Staff actively encouraged people to make the home their own.

Ensuring consent to care and treatment in line with law and guidance

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.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People told us staff always asked for their consent and that they were happy before supporting them. We observed staff consistently asked for consent before helping people. Staff we spoke with had a good understanding of the principles of the MCA and people were supported wherever possible to make their own decisions. A staff member told us, "It's about making sure they have a choice, making sure they have the right information to decide what they want, where they can."
- When people lacked mental capacity, the registered manager had ensured that decisions were made in each person's best interests. This included consulting with relatives and healthcare professionals when a significant decision needed to be made about the care provided. For example, one person did not have capacity to decide around having their medication. A best interest decision was made in conjunction with the GP, Pharmacist and the registered manager that covert medication would be used as this person's health would deteriorate without the medicine.
- Where a decision had been made to restrict a person's liberty DoLS applications had been made. Applications had been submitted to the local authority. The registered manager sent us a tracker to show that all the DoLS applications had been reviewed or renewed where required.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

Good: This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staff were kind and caring towards them. One person told us, "Yeah they [staff] are kind." Another person told us, "Yes always." When asked if they felt staff were kind and caring.
- Relatives told us they felt staff were caring towards their loved one. A relative told us, "Yes they are [caring]. [Carer] is lovely and plays cards with my Mum and talks about the old days with her."
- Staff spoke to people in a caring manner and acted to reassure people when they needed it. One person had become upset and said to staff, "I am stupid." We observed the staff member reassure this person in a kind and caring manner taking time to ensure the person could settle. We observed staff complementing people on their new haircut after they had seen the hairdresser. People had smiled when receiving the compliments.
- A professional told us, "When I have been here staff have always been engaging with people, supporting them to keep positive and happy. Staff are always so calm and reassuring with people."

Supporting people to express their views and be involved in making decisions about their care

- People's religious wishes were respected, and people were supported as needed to continue practicing their chosen faith. One person had a specific diet due to their religion. The provider has ensured that a representative acting on their behalf who is of the same faith visits the person to discuss any religious needs.
- Staff asked people what they wanted to do and offered choices to meet people's needs. We observed a member of staff supporting a person and being patient, offering choices about what the person might want to do for lunch. The staff member worked through the choices and ensured the person understood. This enabled the person to make a choice to go into the dining room for lunch.
- People and relatives had input into the reviews for care plans. We saw from records that care plans were reviewed, and a tracker was in place to highlight when a review was due. Relatives told us, "Yes I am aware and was involved [with the care plan and review]." Another relative told us, "My step daughter is [involved in the reviews]."

Respecting and promoting people's privacy, dignity and independence

- Staff were respectful of people's needs, for example making sure they were at the same level as people when they spoke with them. We observed staff at lunch ensuring they approached people who were sat in chairs at their level and addressed them in a caring a respectful way.
- Staff were respectful of people's personal space and ensured they asked permission from people. We

observed staff knocking on people's doors before entering. Staff always told people who they were and what they needed before entering a person's room.

- Staff understood the positive impact supporting people to maintain their independence had on people's wellbeing. One staff member said, "We do have a lot of people who rely on us to do things for them, I do try and encourage people where I can to do as much for themselves as they are able to. People here have different needs so it's about being open and supporting people to achieve the best they can."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

Good: This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans contained the relevant information based on their needs. People who were identified as having behaviours that challenge had guidance in place for staff in how to support the person. For example, one person who could become anxious there was guidance directing staff to speak calmly and offer a distraction or something else for the person to focus on.
- People had care plans which had been developed by gathering information from them. Families were included to build a picture about each person care needs, preferences and history. People's care records provided information about their life history, cultural and spiritual needs and activities they enjoyed. A staff member told us, "In the care plan there is an activity and interests' section. I am updating every month with additional information that I receive from people or families."
- Staff responded to people's needs and care plans contained detailed guidance for them to follow. For example, one person who had come into the home from hospital with pressure sores on both heels. They had a wound care chart which had been accurately recorded. They also had photographs which were dated showing the improvements this person had made. A relative commented, "I would like to thank [registered manager] and all your staff for looking after [person] and getting her pressure sores sorted. I only saw lovely, friendly staff and good food."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There was information in place to enable the provider to meet the requirements of the Accessible Information Standard (AIS). Each person had a communication care plan, recording any visual problems or hearing loss and instruction for staff about how to help people communicate effectively.
- One person who was registered blind had guidance within their care plan to guide staff around supporting them. Staff were also aware of how this person chose to communicate. A staff member told us this person would raise their hand in the air as a way of signalling they needed some support. Staff also stated they would read any letters or correspondence to the person. This included reading through the care plan with them, so they had the option to voice their opinion.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

- The provider had employed two well-being coordinators to develop activities for people. This meant that activities could be facilitated seven days a week. As a result, people had well developed activity plans which had sought views and feedback from people living in the home. A person told us, "We do a lot of activities here. We have got two full-time staff on it now. There is lots of entertainment coming in."
- Staff understood that each person was an individual and provided activities tailored to them. For example, baking club, gardening and arts and crafts were areas of interest people had asked to be included in the activity scheduling. There was a weekly activity calendar in the entrance area, so people knew what would be taking place.
- Staff adopted an inclusive attitude for everyone in the home to reduce the risk of social isolation. People who were mainly cared for in bed or chose to remain in their rooms were included in the planning for activities. Well-being staff ensured they visited people in their rooms each day. A staff member told us, "Most of our residents are quite frail in bed. Some just want you there for some emotional support and to have company. Some will play a board game with you or do some exercises with you. I don't want people to be isolated."
- People had taken part in trips or visits out into the community. At Christmas staff had organised for people to attend Hampton Court Palace to go ice skating. Staff made sure the event was accessible to people, such as people in wheelchairs. Whitegates were the first home to support people to go ice skating under the providers services. After it's success the provider made it a companywide activity for people in their other homes. A person who attended the event had commented, "Today has brought back such special memories of when I used to go ice skating many years ago. We're very grateful to the staff at Whitegates for arranging such a lovely day out for us."

Improving care quality in response to complaints or concerns

- The provider had a complaints policy which people, relatives and staff knew how to utilise. We saw where complaints were made, these were investigated, and the complaints policy followed by the registered manager. The registered manager reviewed complaints with the regional manager to ensure complaints had been responded to in line with policy.
- People and relatives told us they felt comfortable raising any complaints or concerns to management. A person told us, "If I need to mention anything then I can speak to staff or the manager. I wouldn't hesitate in telling them if something was wrong." A relative told us, "I have mentioned a few things to the manager before and they have been sorted, I have not needed to complain formally but I would know how to if I ever needed to."

End of life care and support

- People were supported at end of life by staff who were knowledgeable and were aware of national best practice guidance. The service had been accredited and implemented a national standard (Gold Standard Framework) for people with palliative care needs. This involved a holistic approach catering for the person and their loved ones ensuring there was good communication.
- The management team and staff had established close links with a local hospice. Staff from the hospice would attend the home to review medication, check pain management, positioning and mouth care. This ensured that people experienced a comfortable, dignified and pain-free death.
- People's preferences relating to end of life were recorded. This included funeral arrangements and preferences relating to support. The home ensured these preferences took account on people's cultural and spiritual needs. One person had details in their care plan relating to their religion and taking into account their cultural needs following end of life.

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 deteriorated to requires improvement.

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

- The provider had quality assurance systems in place which were not always effective. The provider and registered manager had previously identified issues with recording of fluids. However, Quality checks on food and fluid charts had not been maintained to ensure improvements had taken place as they had not identified the shortfalls we found on inspection. Staff felt that management were aware of the issues but had not suitably resolved them.
- Some staff members told us they did not always have confidence that records were being kept accurately. Some staff told us they felt there was an over reliance on permanent staff to check records being made by some agency staff. This put more pressure on staff members to complete additional checks and despite this and reminders being given there were still gaps in recording of information. Staff felt that management were aware of the issues but had not suitably resolved them.

We have 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.

- Nurses conducted observations to ensure safe practice was maintained by staff. These observations included communication, attitude of the care worker, delivery of personal care, meals, manual handling and medicines administration.
- Although we found shortfalls with some quality audit processes the provider conducted other quality checks to drive improvement. For example, a wound care audit had been conducted regularly to ensure best practice was being followed. The audit processes found that people were receiving the correct care and wounds had improved and healed. Other examples of quality checks were health and safety, medicines, fire safety and call bell audit.

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

- Overall relatives and people were positive about the management team at Whitegates. A relative told us, "[Registered manager] always comes over and chats. Everybody is so friendly and chatty." Another relative commented, "There is a great deal of humanity in this home and [registered manager] leads by the example that she sets."

- People told us they were happy living at the home. A person told us, "It is very, very nice." Another person told us, "I think it is brilliant. I am very pleased."
- Staff were complimentary of the support they received from the management team. A staff member told us, "I can go to the nurse or to the deputy manager. [Deputy manager] is really helpful. She is very nice and easy to talk to. [Registered manager] always goes around in the mornings, she always talks to the carers." Another staff member told us, "[The Registered manager] door is always open. She is never too busy."

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 provider met their responsibilities in relation to duty of candour. We saw from records that families had been notified of any incidents or accidents and apologies had been given as and when required.
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

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

- People and their relatives were encouraged to contribute their views on an ongoing basis through a survey which was sent out quarterly. We saw feedback had been gathered had been analysed by the registered manager and regional manager. All the responses received had been positive from the most recent survey and this data had been shared with staff.
- People and relatives' meetings were held regularly at the home. This enabled people and their families to have their say and hear updates. We observed from records the registered manager gave feedback to people around issues that had been raised at the previous meeting. For example, feedback was given at the latest meeting around night staffing and clothing being damaged. Reassurances had been given to families over the amount of staff on duty at night and all staff had been spoken to around the handling of clothing and ensuring any damages were reported immediately.
- Regular staff meetings took place to give staff an opportunity to discuss any changes to the organisation, working practices and raise any suggestions. Separate meetings took place for nursing staff, care staff and maintenance staff. Any action points were noted, and feedback given for improvement. For example, it was noted that there had not been enough space to record people's daily activities, so a new form was designed and implemented based on this feedback. This enabled all one to one activity with people to be recorded.

Continuous learning and improving care; Working in partnership with others

- The service had developed a close working relationship with the community mental health team (CMHT). We observed from people's records that the CMHT had been working with people within the home around their mental health.
- The service worked in partnership with health and social care professionals to ensure people received support to meet their needs. Close links had been developed with the GP, tissue viability nurse (TVN) and speech and language therapists.
- Records showed the provider worked closely in partnership with the safeguarding team and multidisciplinary teams to support safe care provision. Advice was sought, and referrals were made in a timely manner which allowed continuity of care.
- The management team attended various events and forums to share best practice and look for learning opportunities. The regional manager told us the management team link in with the local Clinical Commissioning Group (CCG) in order to attend meetings.

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 The provider failed to ensure risks to people were monitored. Putting people at risk of harm.